January, 1958

MENTAL HYGIENE

Published Quarterly by the
National Association for Mental Health

Quarterly Journal of the

National Association for Mental Health, Inc.

George S. Stevenson, M.D., *Editor*
Harriett Scantland Hoptner, *Assistant Editor*

MENTAL HYGIENE

MENTAL HYGIENE aims to bring dependable information to everyone interested in mental problems. Here are original papers by writers of authority, reviews of important books, reports of surveys, special investigations and new methods of prevention and treatment in the broad field of mental hygiene and psychopathology. Our aim is to make MENTAL HYGIENE indispensable to all thoughtful readers. Physicians, lawyers, educators, clergymen, public officials and students of social problems find it of special value.

$6.00 a year (Canadian $6.25; foreign $6.50). Single copy $1.50. Publication office: 374 Broadway, Albany 7, N. Y. Editorial and business office: 10 Columbus Circle, New York 19, N. Y. Second class mail privileges authorized at Albany, N. Y.

VOLUME FORTY-TWO, NUMBER ONE *January, 1958*

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BERTRAM MANDELBROTE, B.Sc., M.B., M.R.C.P., D.P.M.

An experiment in the rapid conversion of a closed mental hospital into an open-door hospital

The importance and therapeutic value of the "atmosphere" in a mental hospital community has been increasingly recognised, depending on improving mutual trust between staff and patient, and necessitating a change of roles for both nurse and patient. It is felt that keys and locked doors, railings and fences do much to destroy this relationship and perpetuate anxieties and insecurities felt towards one another. The paranoid patient feels more resentful, the recent admission more afraid of entry into the mental hospital; there is a challenge for the more rebellious and the long-stay patient tends to become isolated and dependent.

In view of this several physician superintendents have proceeded with the experiment of unlocking the doors of the mental hospital, and at least four mental hospitals in Britain have opened all the doors and dispensed with locking procedure throughout the day. Rees (1, 2, 3) at Warlingham Park was one of the first to emphasise the importance of a therapeutic community in which open doors were a vital part of the concept, and for several years this hospital has managed with two locked doors, which have more recently also been opened (thereby completing an experiment of 20 years' duration).

Bell (2, 3, 4) at Dingleton Hospital in Scotland, MacMillan (2, 3) at Mapperly Hospital in Nottingham and Stern (5) at the Central Hospital, Warwick, have also unlocked all the doors of their mental hospitals. In these hospitals the procedure was introduced very cautiously and over many years. It was constantly emphasised that unlocking the doors was the last procedure to

Dr. Mandelbrote is physician superintendent and consultant psychiatrist at Coney Hill and Horton Road Hospitals, Gloucester, England.

be adopted after due attention had been given to the occupational organisation of the patients and the re-education of the nursing staff.

PROJECT

This experiment was conceived after experiencing the therapeutic benefit to patients living under these conditions, where their positive assets were utilised and much emphasis was placed on mutual trust. In many respects Coney Hiil and Horton Road were ideal hospitals for this project. They had been run as completely closed hospitals with a rigid policy of separation of the sexes and were very overcrowded. Little attention was paid to social and cultural aspects and morale was at a low ebb, although from the point of view of physical treatments a moderately high standard had been maintained.

At these two hospitals there were 1,436 patients (746 at Horton Road and 690 at Coney Hill) [1] in accommodations for 1,220. The staff consisted of 6 medical officers, including the physician superintendent, and 201 nurses of whom 65 were part-time (a nurse/patient ratio of 1 to 7). Patients were equally divided throughout the two hospitals and at that time new admissions and placings depended on whether the patient was seen by the superintendent, who was based at Horton Road Hospital, or his deputy at Coney Hill (these were the only two consultants on the staff). As a result the populations of the two hospitals were very similar, both containing their proportion of chronic schizophrenics, geriatric and epileptic problems, which constitute the greater segment of patients in mental hospitals in Britain. Both hospitals were old. Horton Road, situated in the city of Gloucester, was built in 1824 and for many years had been regarded as unsuitable for its function as a mental hospital, on account of its antiquated building. There were long corridor wards, labyrynthine passages some below ground level, stone staircases, inadequate heating facilities and absence of dormitory and day space. The entertainment hall had been occupied with 56 beds since 1939. Throughout the war many patients had been evacuated here resulting in overcrowding. No classification of patients was considered possible on account of the overcrowding and shortage of staff. Large quantities of sedation were used. Many patients were confined to bed; others were in bed by 7 p.m. and in some instances patients started putting themselves to bed by 4:30 p.m.

HOSPITAL SETTING

Horton Road has 36 acres of ground and is situated in very close proximity to the city general hospital near the heart of a highly industrialised city with a railway junction adjacent to the hospital. It is surrounded by a thickly populated working class area on the one side and a slightly more residential middle class district on the other. A major road passes the front gates of the hospital, and the front door is set back not more than 30 yards from the roadway.

Coney Hill, the sister hospital under the same management, is a little more than two miles away in a more picturesque rural setting with 230 acres of farm land and the Cotswold and Malvern Hills in the distance. It too is very close to the city and adjoins a housing estate, but the

[1] The figures now are 1,325 (590 at Horton Road, 735 at Coney Hill) in accommodations for 1,304, with a staff of 10 medical officers.

grounds are such that it has a rural atmosphere. It was built in 1883. Its construction is typical of the mental hospitals of this late Victorian period, of which there are many in England, and it more closely resembles some of the hospitals which have already opened their doors.

These two hospitals serve the county of Gloucestershire (except for its extreme eastern boundary) with a population of 412,000 people in an area of 1,100 square miles. The staff of these hospitals provide the psychiatric services for the county in conjunction with the medical health services of the local authority, which staff the child guidance unit. In addition there are six duly authorised officers who supervise mental defectives in the community and are called in to deal with acute behavioural problems which may require observation.

This experiment was started in May 1956 and was made more feasible by three favourable aspects:

- Two new units adding accommodation for 84 patients were completed at the commencement of the experiment.
- A change of hospital policy was anticipated.
- The hospital was serving a local community, and was concerned with providing a complete psychiatric service for this community.

Before any real change could be effected in attitude and morale, and before hospital doors could be opened, two important stages in the experiment had to be planned:

- The proper classification of patients.
- The organisation of better social interaction between members of the hospital community, both patients and staff. Special consideration had also to be given to the organisation of the patient's day, especially in relation to occupation. Finally, there was the problem of educating the community to a change of policy in the treatment of mental illness.

CLASSIFICATION

Overcrowding and shortage of staff had handicapped classification very gravely in the past but did not by any means make this impossible. A form of classification along behavioural lines was designed. The concept of an admission ward was dispensed with, and patients were classified in behavioural categories before admission to hospital. Behaviour also determined movement from one ward to the next, after the classification had been completed. (This necessitated a better liaison between general practitioners, local authority officers and facilities for a better out-patient service and more domiciliary consultation, which is steadily being improved and extended.) Each unit was then divided into small groups under the special supervision of a nurse, who planned the patients' days with the assistance of ward doctor and sister [2] in charge of the ward. Each ward sister compiled a list of her patients with details of their behaviour, occupational abilities and special idiosyncrasies. The personal contact established by having the same nurse planning the daily occupation and social activities of her own patients was invaluable in improving behaviour and relationships on the chronic wards where personal contact had been very limited. The 16 units at Coney Hill and the 14 units at Horton Road resolved themselves into the following behavioural categories:—

[2] The American equivalent of "sister" is supervising nurse. The term "nurse" is used to cover all ward personnel working with the patient.

1. Incontinent ward for all but the elderly, frail and infirm (organised along the lines of a habit-training unit).
2. Infirmary ward.
3. The elderly incontinent and frail geriatric unit.
4. Long-stay moderately well-integrated patients who were not incontinent and were not acutely excited.
5. Long-stay as above, who required minimum nursing supervision.
6. Acute behavioural disturbances, mainly acute psychotic states.
7. Epileptics requiring observation and chronic patients with behavioural disturbances.
8. Recent admissions without gross excited behaviour, including depressives, early schizophrenics, paranoid states and hypochondriasis.
9. Recent admissions (mixed unit) for male and female patients who could participate readily in group discussions and benefit from some form of group psychotherapy, including neurotics, alcoholics, personality problems (non-psychopathic) and depressives who were not acutely agitated.
10. An observation unit for new cases sent in under section order (short term up to 28 days) for observation. This consisted of a small dormitory unit rarely exceeding 5 to 10 patients.

By this means it was possible to readjust our limited available staff to meet the demands of the wards requiring the greatest nursing participation and organisation, i.e., the habit-training ward, the infirmary ward and the acutely disturbed wards. This rough classification with the rearrangement entailed was completed in little more than three weeks.

One of the distressing aspects in the hospital was the uriniferous odour produced by the use of antiquated chambers in all the dormitories. This was one of the first problems tackled. All the chamber pots were removed (with the exception of a few closets for the very elderly, infirm and frail) and habit-training was so reorganised that patients were encouraged, helped and coerced to use the toilets regularly. The hospital became a turmoil of activity despite the fact that many of the nursing staff were very sceptical about the outcome.

Nevertheless, in the past setting of apathy and inactivity, changes were welcomed by many and the lack of cooperation was minimal. All the senior nurses were asked to report the problems that they were encountering in relation to the removal of the chambers, and surprisingly enough, at the end of a fortnight, only two male patients presented overt difficulties.

The complete story emerged only later, however, when it was found that several of the female patients would hide these chamberpots under their clothes and carry them wherever they went. Apart from a few adamant letters no further difficulties occurred. It is very interesting to see now how many patients have taken the responsibility of looking after their incontinent or less fortunate colleagues. Many patients participate with the nurses in the habit-training régime of taking fellow patients regularly to the toilet and helping them with their dress and eating habits at the table. The willing and most competent of these have been made leaders of small groups of patients.

IMPROVING SOCIAL INTERACTION

At the same time as classifying the patients, considerable attention was turned to the problem of improving social interaction in the hospital community. It was decided

that there should be a platform to enable all patients and staff to express their ideas and discuss their problems. Regular weekly meetings with the heads of all staff departments—medical, nursing and administrative—were arranged with the physician superintendent. At these meetings the matron, chief male nurse, laundry manager, group secretary, finance officer, supplies officer, catering officer, hospital engineer, clerk of works and physician superintendent attended regularly to discuss problems that arose, including difficulties in interdepartmental communication and plans for improving hospital relationships. Other members of the staff were invited to attend when their problems were discussed. All matters subsequently raised with the hospital management committee were previously discussed at the meetings of the heads of staff. It was very interesting to see initially what extreme tension and hostility was present between the nursing staff and administrative staff, and how these difficulties were used as an excuse for inertia.

The matrons and chief male nurses in turn were assisted in organising regular group meetings with their charge nurses and sisters, enabling free expression of problems on the ward and ideas for improving staff and patient relationships and conditions. Matters arising from these discussions were subsequently brought up to the heads of staff meetings. Doctors began to hold group meetings with nurses and patients on each of the wards. As stated previously, each ward was divided up into small group units (6 to 10 patients) under particular nursing staff; these units had a planned programme which was very much dependent on the level of integration and behaviour of the patients concerned. This varied from group psychotherapy and discussions on the most integrated wards to practical occupation, habit-training programs and primitive play therapy techniques in the less integrated longer term patients.

Direct contact of patients and staff with the physician superintendent was encouraged wherever possible. Suggestion boxes were placed at convenient sites where suggestions and complaints went direct to the superintendent, and all letters with grievances were forwarded and resulted in an early hearing for the patient. New cases were seen by the physician superintendent and letters from the patients' sports and social club were submitted directly to the heads of staff conference. In this way a personal contact was developed between the physician superintendent and the more difficult and complaining patients of the hospital, and legitimate grievances were voiced.

OPENING OF HOSPITAL DOORS

With the completion of the classification and the commencement of the programme outlined above, with additional emphasis on the need for providing better social, cultural and occupational facilities for the patients, the doors of the hospital began to open.

The main hospital doors were the first to be opened. The hospital gates had always been open as the hospital entrance was a quarter of a mile away, and the main hospital doors had always been completely closed except to a small number of parole patients. Efforts had already been made to encourage mixing between the male and female patients, which previously had been rigidly restricted. The dividing doors separating the male and female sides of the hospital were the next to be opened, and then the doors of the individual wards

of the hospital began to open. It was pathetically amusing to see how strange it was at first for male and female patients to wander into one another's sections. But this was soon to change as mixed units and mixed discussion groups and social functions developed.

At the end of the first month 10 out of 16 wards were open.

For the first time since 1951 the entertainment hall at Coney Hill was cleared of beds and as a result of much energy and enthusiasm an extensive social and entertainment programme was designed and has been continually developing. Dances were organised weekly and then twice weekly, concert parties, stage shows, whist drives and games were arranged. As the months elapsed patients began to play an increasing part in the organisation and integration of these functions. A patients' sports and social club was formed, also a music club and a drama club. A hospital magazine was started and regular outings for the long-stay patients were arranged. Domestic science classes and re-education in household duties were planned for the less disorganised long-term female patients; whilst the energies of the aggressive and resentful young male patients were turned towards pulling down hospital railings and designing and laying out a new putting green, croquet lawn and flower beds. Within a short space of time, the atmosphere in the hospital changed from apathy to activity. A further outlet for patients' grievances was met in the provision of a regular food conference—meetings between elected representatives from each of the wards and the representatives of the nursing, medical and catering staffs.

To alleviate the shortage of nursing staff, volunteers from the best units were utilised as group leaders for small groups of long-stay patients and assisted in their occupational organization under the guidance of the occupational therapist. These group leaders underwent a short course of intensive training in the same way as did the nurses before taking up their assignment of chronic patients. This gave some of them an outlet for their need to contribute to the hospital community and many gained confidence in their newly found qualities of leadership.

The success with which this was undertaken was quite contrary to expectation, for I had anticipated that the majority of recent admissions would resent working with long-term patients and complain of increasing activity. Instead, the majority reaped considerable benefit from the experiment and the long-stay patients improved enormously. I think their surprise at finding that they actually had therapeutic assets was the greatest boost to their morale; very few patients became more anxious in this setting, and these were not pressed to continue. Several patients after discharge have returned as volunteer helpers wishing to continue the work they commenced whilst in hospital.

The next move, the further opening of the doors, presented problems for the medical and nursing staff. The only wards still closed included those where cases were admitted for observation under a short-term order, the more acutely disturbed wards, and wards with chronic restless patients who were branded as destructive, aggressive, wanderers and repeated absconders. The 5 wards included the male incontinent ward to which absconders had always been allocated, the acutely excited ward, the habit-training ward and 3 wards with restless chronic female patients who would either wander aimlessly or were known absconders.

Attention was first directed to the wards

with known absconders. Only 11 patients out of 50 were considered totally unsuitable for trial on an open ward. This was a ward composed mostly of chronic paranoid patients very resentful of detention. Entering this ward, which was always locked, frequently resulted in bumping into patients who were awaiting a chance to get outside, and the nursing staff were acutely concerned and preoccupied with the need to keep these patients from getting out while the door was rapidly unlocked and locked again. Of these 11, 6 were distributed amongst the other wards still locked and 5 of the most difficult were sent to Horton Road, which at that time was essentially a closed hospital (although even at Horton Road 7 out of 14 doors had been opened during this period).

It is important to emphasize that interchange between the hospitals had not been the policy previously, and that all interchange until the 5 patients were sent to Horton Road has been primarily related to upgrading of patients from Horton Road to Coney Hill as the problem of overcrowding became less acute.[4] These 5 were considered to be the most difficult people to manage in an open hospital and were moved to Horton Road to reduce some of the tensions that were beginning to develop amongst the nursing staff and doctors at the thought of the further opening of the hospital. What happened to these 5 patients is interesting. They were given considerable personal attention and their management on an "open" ward is no longer a problem. Four are on open wards at Horton Road and the last is living in one of the hospital annexes for elderly and chronic patients who present no special problems, require minimum supervision and are allowed to shop freely in the town.

Of the other 6 patients (who were initially transferred to locked wards) 1 has been discharged from hospital and the remaining 5 are now on open wards at Coney Hill. Following on the transfer of these patients, 3 further wards were opened, and increased nursing staff was allocated to these wards, leaving only 1 closed ward on the female side of the hospital after four months of experimenting with open doors. There were two further instances of transfer prior to the formation of a closed group. Two male patients were involved in incidents likely to affect public safety and were transferred to Horton Road. One, a chronic schizophrenic, frightened a child in the neighbourhood and caused local concern; the other, a chronic but well-integrated paranoid patient, had threatened to harm his wife as a result of his delusions of her infidelity. He had absconded on two previous occasions when the doors of the hospital were locked and ran away again shortly before his transfer. Both these patients are now on a closed group in open wards at Horton Road Hospital.

CLOSED GROUP

It was at this stage that the concept of a closed group for repeated absconders was decided upon. By this time there had been several patients who had left the hospital without permission, and for them there was a standard procedure. Each morning at a doctors' and heads of nursing staff conference, all discharges from the hospital were seen and also all patients who had absconded. They were placed in bed for 24 hours on their return to hospital. Each patient was seen personally by myself and an attempt was made to understand why

[4] The population at Horton Road has been reduced from 746 to 590.

he had gone and there was discussion about mutual trust and locked doors. The patient was prevailed upon to promise that before deciding to leave the hospital he would discuss the motivating factors of his problem with the matron, chief male nurse or doctor in charge of his case. Repeated absconders were placed in a small closed group, consisting entirely of repeated absconders, under the constant supervision of a nurse who was responsible for planning their day. The number of patients in the closed groups rarely exceeds 6 and consists mostly of dementing or chronically hallucinated patients with whom little contact can be made.

Over the past nine months no patients have been transferred, and with the use of the closed group and early treatment of the acute psychotic, all absconders have been easily managed at Coney Hill Hospital. Even more extraordinary has been the very low number of absconders; the pattern of absconding has also been changed in that the majority of people who are absent without leave from the hospital go to their homes and are not infrequently brought back by their relatives.

COMMUNITY PARTICIPATION IN THE MENTAL HOSPITAL

By this time members of the community were becoming more aware of changes taking place in the mental hospital and were beginning to develop a greater interest in what was happening in the hospital. Some were very anxious about the opening of the doors and the dangers that might hold for the public, but the majority were rapidly converted to the idea of less restriction and were pleasantly surprised when they saw the developing air of normality in the hospital. Throughout this period attempts had been made to interest important small public groups in mental health matters and talks were given by myself to the Rotary Club, the Soroptimists, Professional and Business Women's Club, Round Table, Disablement Settlement Officers, local magistrates, district nurses, health visitors and other local and influential groups.

Many joint meetings were held with the medical officer of health and the local authority officers in order to develop a scheme whereby the majority of problems of mental illness were not directed into the mental hospital either as voluntary or certified patients, but were first seen by a psychiatrist and later by a psychiatric social worker, either in the out-patient clinic or in their home. In this way it was possible to reduce the incidence of certified patients to a minimum and to use a short-term order (section order, extending up to 28 days) for disturbed patients requiring observation and treatment and lacking in insight. The use of these section orders increased for acutely disturbed people, but patients were classified and directed to their correct behavioural ward where they were soon integrated into the life of the hospital community. This reduced considerably any unwillingness to remain in the hospital after the order expired, and in only two instances over the first year was it necessary to certify patients admitted on a section order (this was out of 170 section orders admitted). In several cases a second section order has been necessary, but in only four instances was the order repeated on several occasions. Over the past nine months of this procedure it has not been found necessary to certify any patients. By November 1956 the last door at Coney Hill was opened, six months after the experiment had commenced.

Since November 1956 the doors at Coney Hill have remained open and many com-

plaints would be raised by patients and staff if an attempt were made to lock them again. In fact it is quite amusing to see in the *Coney Clarion,* the patients' magazine, remarks indicating that the locking of certain doors at 8:30 p.m. was upsetting to patients. As the morale of the hospital has increased, concern about open doors has lessened very considerably, and patients who misuse privileges are brought to task by other patients in group discussions. The problem of the wandering of senile and chronic patients is not nearly so grave as anticipated and the use of a closed group reduces this problem. It is quite interesting to note that better integrated patients often bring back more chronic patients who tend to wander away aimlessly. At Horton Road the experience at Coney Hill has resulted in the rapid opening of all the doors on the female side with very little increase in the absconding rate. So far, 14 patients have left the hospital, in two instances to avoid having E.C.T., which was for them a very traumatic experience; in almost every case the patient has returned home. Every encouragement is given to patients to go home for weekends. On admission the patients and their relatives are helped to appreciate the fact that their stay is a temporary one and that further treatment and contact can be maintained with the hospital when they are at home in out-patient clinics.

The patient no longer feels detained against his will with hopeless prospects; by seeing so many people given increasing freedom and leaving hospital, he feels encouraged that his needs will receive attention and his grievances will be considered.

The relationship with the community has improved considerably. A very active League of Friends has been formed and visitors to the hospital are frequent. Women's Institutes regularly entertain groups of chronic patients to tea and many members of the general public are eager to assist patients in some way or other. The relationship with Women's Institutes is an interesting one. It started with a circular from Women's Institutes' meetings all over the country that more should be done for the rehabilitation of the mentally ill. The hospital had acquired a bus to take chronic patients out for drives in the afternoon (patients who had often not seen the outside of the hospital for many years), and the first Women's Institutes with some trepidation asked about entertaining busloads of patients to tea; since then this has become a regular feature. In only three instances have situations arisen which have caused concern and resulted in telephone calls to the physician superintendent. In one case women were frightened by the presence of a chronic patient who had settled down in a ditch near their farm door; in another a disturbed schizophrenic was found pulling up flowers in a nearby garden; whilst the most serious offence was an effort on the part of a chronic schizophrenic male patient to accost the young daughter of a local magistrate. Fortunately all these situations were handled tactfully and did not result in additional pressures being brought to bear on the hospital to close its doors.

REACTIONS OF THE NURSING STAFF

Surprisingly enough and contrary to expectations (6) the reaction of the nursing staff has been a very favourable one with a minimum of resistance on the part of the older nursing staff. Some of the reaction against the opening of the doors may have been masked by lack of adequate investigation but all the charge nurses and sisters were given the opportunity of submitting an

anonymous report which was placed in the suggestions box and all were asked to be frank and critical and especially to express adverse comments. Out of 12 charge nurses or sisters 10 responded to the request and in only one instance was there a suggestion that certain wards would be better closed; every letter brought forth an enthusiastic response indicating a much improved relationship between staff and patients.

RESULTS

There has been a radical change in the type of sedation and the amount used. In comparing a 3-month period prior and subsequent to the programme outlined it can be seen that paraldehyde and chloral hydrate are no longer used extensively. Barbiturates, especially sodium amytal, are used most frequently now but the total quantity of barbiturate used has dropped very markedly; whilst with increasing emphasis on the specific use of tranquilizers the quantity of Largactil used has increased, not as a substitute for sedation but rather as a more specific therapeutic agent in schizophrenia (see Table I). All the patients on Largactil are ambulant except for the rare case that feels unwell, and the majority are participating in the extensive hospital occupational and social integration programme. Night sedation has dropped now that patients go to bed at more normal times after a day of planned occupational activities, and television at nights has helped to keep many disturbed patients interested and quiet. There have been occasional nights when no sedation has been necessary on the female side of the hospital.

The effect on the number of patients confined to bed, the number of fractures occurring and the extent of incontinence in the hospital is shown in Table II.

The number of patients confined to bed has been reduced from 100 to 20 patients; whilst the figure for incontinent patients have fallen from 120 to 45. A total of 21 fractures occurred during the year in both hospitals, 13 in the first six months prior to the complete opening of the doors and 8 in the succeeding six months. Whatever the significance the reduction of patients confined to bed did not increase the fracture incidences.

TABLE I

Sedation before and after opening the hospital doors, by type and amount of drug

	THREE-MONTH PERIOD BEFORE OPENING DOORS *(April–June 1956)*	THREE-MONTH PERIOD AFTER OPENING DOORS *(April–June 1957)*
Paraldehyde	40 litres	7½ litres
Chloral hydrate	8 kilograms	2 kilograms
Barbiturates	1,520 gms.	400 gms.
Largactil	2,755 gms.	3,165 gms.
Pacatal	–	450 gms.

Average nightly sedation (random evening):
14 patients on night sedation, 6 drachms of paraldehyde, 30 grs. of barbiturate.

TABLE II

Comparison in number of "incidents" before and after opening the hospital doors

	SIX MONTHS BEFORE OPENING DOORS *(April–June 1956)*	SIX MONTHS AFTER OPENING DOORS *(April–June 1957)*
Absconders	28	29
Destructive and impulsive patients	123 (average)	30
Seclusion	236	40
Bed patients	100 (average)	20
Fractures	13	8
Number of E.C.T. treatments	1,095	715

ASSAULTS AND IMPULSIVE AND DESTRUCTIVE BEHAVIOR

In the six months prior to the opening of the doors 123 incidents of destructive and impulsive behaviour were recorded, and seclusion was used on 236 occasions. In the six months following the opening of the doors the number of destructive and impulsive outbursts has dropped to 30 and seclusion has been used in only 40 instances. Since these figures were compiled, destructive and impulsive outbursts and the need for seclusion has diminished further.

HOSPITAL POPULATION

The total number of patients in the hospital has fallen from 1,436 to 1,325 despite the fact that the admission rate to hospital last year was the highest in the history of the hospital (755 patients) and the death rate was falling.

DISCUSSION

There has been a great deal of interest recently in British hospitals in the advisability of an open-door policy in mental hospitals. Some psychiatrists, especially those who are in charge of mental hospitals that have opened their doors, are adamant that the restriction produced by locking doors has a markedly adverse effect on the relationship between the patients and the staff. Furthermore, the consciousness of captivity adds a variety of additional symptoms and preoccupations which would never be present if their liberty were not unduly restricted. Dr. Bell maintains that a single locked door in a hospital will affect the morale. On the other hand, many psychiatrists regard it impossible and hazardous to run a mental hospital without locked doors. It has been said that violence and suicide from the acutely disturbed patient will increase, that senile and chronic patients will wander off and cause harm or come to harm, and that these patients could be kept in an open hospital only by an increase of sedation, abuse of confining patients to bed and excessive physical treatment.

My conclusions are to the contrary. With the opening of the wards there has been a reduction of aggressive and impulsive

behaviour, seclusion has diminished considerably, there is less withdrawal and better contact between the patients and the staff. Delusions tend to recede into the background, and with less disturbed behaviour and more participation in hospital life there is better opportunity for improving social interaction and rehabilitation. If we examine the question of abuse of bed rest, excessive sedation and physical treatment it becomes evident (see Table I) that confining to bed has reduced considerably, sedation has lessened and there has been no increase in physical treatments. Largactil is being used to a greater extent as its efficiency in the treatment of acutely excited states and chronic schizophrenics is being realised, but this increase has not occurred in relation to sedation or the prevention of absconding.

An interesting aspect of this experiment has been the speed with which this programme has been carried out with few untoward effects. The hospitals that have previously opened doors have done so after a long period of years and it has often been stated that this could be done only by a very gradual adjustment. In this instance all the doors at Coney Hill were opened within a period of six months and there is no doubt about the beneficial effects this has had on the morale of the hospital. In my opinion, this could only have happened concomitantly with organised classification and improved social interaction. This was achieved by grouping the patients and planning their daily programme with emphasis on occupational, social and cultural activities, by attending to their needs and assessing their grievances as they occurred. It may seem somewhat naive attempting to deal with mental hospital patients on the basis of trust but it is remarkable how worthwhile it has been.

The majority of absconders now, are not people wanting to escape but wanderers in the older age group and deluded patients responding to hallucinations who need frequent reviewing as to whether further treatment is required. Only 29 patients absconded over a period of six months; of these a few were persistent absconders who would now be on the closed group. If there is sufficient activity and entertainment patients will return to hospital because it provides an interest for them. Even the most chronic patients have developed an increasing interest in hospital affairs as a result of the hospital magazine and the better contact with fellow patients and nursing staff.

The hospital has transferred 54 patients to 3 moderate-sized houses in the town. These patients are now no longer under any statutory supervision. Many more patients in the hospital have now become suitable for this type of accommodation.

Aggressive activity and behaviour has been reduced to a minimum, seclusion is very rarely necessary and incontinence is now on the decline.

Our experience at Coney Hill has resulted in the rapid opening of doors at Horton Road. The last door on the male side of the hospital has recently been opened; whilst the female side of the hospital has been open for the past six months.

The attitude of the nursing staff to the whole problem is very significant and will have an important bearing on the success of an open-door policy. Fortunately, at Coney Hill the nursing staff have been enthusiastically cooperative and now firmly believe that this is the best policy for themselves and the hospital. They are never made to feel that if a patient absconds (except from a closed group) it reflects on their management.

In the beginning many doors were surreptitiously closed on account of the nurses' anxieties, but after nine months of open doors these anxieties appear to have disappeared. Many people would have felt that the number of nursing staff at Coney Hill is totally inadequate for a project of this nature (a nurse-patient ratio of 1 to 8), and on reflection I would agree, but the experiment has been carried out with few if any adverse consequences. It would certainly be an advantage to have a larger nurse-patient ratio, so that group organisation could be better maintained; with a greater number of nurses fewer of the demented and chronic patients would wander off. Yet it is extraordinary that so few patients have absconded, forcing one to conclude that even the more deteriorated patients begin to realise that the hospital environment is a safer and more secure one for them; whilst the others are prepared to accept more responsibility for their actions and lose interest in a challenge which no longer exists.

An experiment of this nature, however, will depend very much on the education and tolerance of the local community and good relationships between the hospital, the police and the press. While undoubtedly this programme has been beneficial for patients and staff in the hospital the question of endangering the public has constantly to be considered.

The majority of British hospitals do not contain sex offenders, criminal psychotics or psychopaths who are definitely dangerous. These are generally sent to Broadmoor (a criminal state institute). In only three instances over the past year have incidents occurred which have resulted in complaints of local inhabitants to the physician superintendent, and fortunately in no case was the incident a serious one.

The closed group is invaluable for dealing with the problem of the few patients who may be regarded as likely to harm the public. Surprisingly enough, there have been no patients in this category at Coney Hill (although many were thought to be so whilst on locked wards). The 6 to 9 patients who are on the closed group are repeated wanderers with whom little contact can be made (chronic psychotics and senile patients). This situation has not arisen through selection of patients as these two hospitals have to deal with all the psychiatric problems occuring in the county of Gloucestershire apart from the dangerous criminal cases which are sent to Broadmoor. Nor is there any question of transfer of difficult problems elsewhere, as no other hospital is concerned with the management of patients from this region in Gloucestershire.

The most important factors determining the success of this experiment are the need for early treatment of acute psychotic and suicidal patients, and adequate grouping of patients and classification on behavioural grounds. Much emphasis needs to be placed on occupation and the organisation of the patients' day.

The results obtained cannot be attributed to any single factor. Largactil has helped some chronic schizophrenic patients to remit and has been valuable in dealing with acute excited psychotic states. In many instances the use of Largactil enabled much more rapid participation of the acutely disturbed patient in the social interaction planned for them. An active discharge policy has played a part in the reduction of the hospital population, and emphasis on maintaining close contact between the patient and his home (assisted by the domiciliary visiting arrangements of the hospital) has helped to reduce insti-

tutionalisation. The effect of diminishing restriction and improving social interaction has been a vital factor in the changes which have occurred. Organisation of chronic patients into regular occupational and social activity groups is gradually resulting in the production of a more homogenous long-stay community in which the behaviour of the chronic patient is rarely disturbed.

SUMMARY

This paper deals with the planning and problems involved in the rapid conversion of a closed hospital into an open hospital, a transition which occurred within a period of six months.

During the time of these changes there has been a fall in the hospital population and a reduction in the amount of sedation. Aggressive and destructive behaviour has diminished as has the number of patients confined to bed. In a hospital with 750 beds there were only 29 absconders over this 6-month period, and this is no more than occurred in the six months previously when the wards were closed.

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ALFRED L. KASPROWICZ

The trial visit patient: Challenge to community agencies

The primary objective of any mental hospital is, and of necessity must be, the care and treatment of those patients currently residing within its walls. Owing to the tremendous overcrowding, a condition which exists in most state mental institutions throughout our country, even this objective cannot be fully realized. The majority of patients receive custodial care. Intensive treatment is reserved for the few who are deemed most likely to benefit from it. Crowded conditions also make it impossible for the doctors and other staff members to know all of their patients as thoroughly as they should.

Ohio's program for the treatment of the mentally ill is divided into two broad areas. Depending upon the nature of his illness and type of commitment a patient is sent to one of two types of institutions. The more acutely ill patients are treated in receiving hospitals for a period usually not exceeding three to six months. If they have not been released before that time they are sent to the second type of institution for further treatment and care. This second type of hospital for the mentally ill is the prolonged care hospital. Here are treated all the chronically ill long-term cases.

When a patient has received maximum hospital benefits an attempt is made to return him to the community. Since the chronically ill patient's hospitalization is usually figured in years, not months, the problem of reestablishing him in the community is fraught with many more difficul-

At the time he wrote this paper Mr. Kasprowicz was supervisor of in-patient service at the Cleveland State Hospital. He is now chief psychiatric social worker at the Waukesha County, Wis. Child Guidance Clinic.

ties than is the return to the community of the acutely ill patient whose hospitalization has lasted only a few months. This is one reason that receiving hospitals do not, as a rule, find it necessary to set up extensively staffed out-patient clinics and can confine their efforts largely to those patients currently within the hospital. For the chronically ill patient, however, the idea of once more taking up life in the community poses many problems—problems he is not equipped to handle alone, perplexing situations in which he needs support and assistance not only from the hospital but also, and to a much greater degree, from the community to which he is returning. This, then, will be the chief concern of this paper—the need for community assistance to those patients being released from prolonged care hospitals.

HIS NEED FOR SUPPORT

Before a patient is officially discharged from the hospital rolls he usually spends some time on conditional release, convalescent leave or trial visit, all of these terms indicating a probationary period during which his adjustment in the community is evaluated. This trial visit period is commonly viewed as a transitional stage from hospital life to community reintegration.

There exist many misconceptions about the patient on trial visit. For example, there are those who hold to the idea, "Once a patient, always a patient." To these people the mentally ill person is a dangerous individual who must be banished forever from the community.

Then we have a more sophisticated group of people who can recognize mental illness as an illness but who are so impressed by modern scientific "miracles" that they fail to see why this illness cannot always be "cured." The thought of there being no complete cure for many psychoses is too threatening to them. From this sort of thinking arises the popular misconception that the patient on trial visit is completely cured and is ready to take his place in the community once more without a moment's hesitation. All that needs to be done is to find him a job and support him with understanding, and he will then once more be able to stand on his own feet. This is by no means always true. In the first place not every patient who leaves the hospital on trial visit is in complete remission from his illness. Although he may no longer exhibit gross psychotic features he may still, nevertheless, be psychotic. It is quite probable that he has been granted trial visit simply because he has achieved "maximum hospital benefits."

The release of such a patient to the community is not necessarily bad. The hospital is a treatment institution, and each patient must profit from its treatment according to his own ability. The hospital cannot, however, revamp a person's entire personality and magically change him into something he never was; nor should it be expected to do so. When the hospital has done all it can do for him we say that he has received maximum hospital benefits, and we attempt to place him in the community. Thus patients leave the hospital in varying stages of recovery.

The criteria which the patient must meet to gain trial visit status are variable. More often than not the decision in favor of trial visit is based upon the absence of hostile or destructive behavior rather than upon the complete recovery of the patient. Another factor which is taken into consideration in the granting of trial visit is the degree of tolerance which his family

shows toward his illness. Thus a patient who exhibits no violent or destructive behavior but who is still hallucinating may be granted trial visit if it is believed his family will tolerate his bizarre behavior.

We tend to forget, too, that many chronically ill patients had made a poor life adjustment for a long time prior to their being hospitalized. Many of these patients came from emotionally impoverished home environments and have experienced inadequate stability and ego support. As Guston states, the chronically ill patient's adjustment to life in the hospital may have been his first satisfactory adjustment anywhere.[1] The authoritarian, parental structure of the hospital tends to foster an unhealthy dependency and a maintainance of the *status quo*. When the patient is finally believed ready for release he feels apprehensive and insecure. Without adequate suppport from the hospital, his relatives and the community the patient may very quickly return to the hospital.

HOSPITAL SUPPORT

In recognition of the patient's need for continued psychiatric help while on trial visit, hospitals have established out-patient clinics where patients can be seen at regular intervals. With the advent of ataraxic drugs some of the more progressive institutions have established treatment clinics to enable patients to continue to receive their medication.

Many clinics fall short of providing the patient with the concrete intensive help he really needs. For the most part they are observational. Treatment is largely confined to the physician's concern for the patient's symptoms and to the dispensing of medication. Social workers find it difficult to do effective case work on account of overwhelming case loads.

Although many hospitals realize the need for expanding out-patient clinic treatment facilities they are hampered by lack of funds and professional staff. They must turn their attention to the more pressing problems of the current in-patient population and do all they can to move these patients out in order to make room for those waiting to be admitted. The community is continually exerting more pressure on the hospital to admit its psychiatric patients. This is particularly true in urban centers where the problem is made more complex by the fact that many young people move out to the suburbs and leave their elderly relatives behind. These aged, many of them having arteriosclerotic and senile mental disorders, help to swell the ever growing list of patients waiting to be admitted to the hospital. Once admitted, these patients tend to become chiefly custodial cases. They occupy beds for a number of years and limit the number of beds available for new patients.

COMMUNITY SUPPORT

Thus far I have discussed only the role the hospital plays in aiding the patient on trial visit. But should the hospital be solely responsible for the rehabilitation of the patients committed to its care by the community? Should not the community also do its share? Let us examine this problem further.

Mental illness is a disease which encompasses a person's total personality in relation to his environment. Psychosis may well be thought of as a social illness in that an individual's adjustment to the com-

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[1] Albert E. Guston, "Group Leave—Planning for Long-Term Patients," *Mental Hospitals*, 5(April 1954), 23.

munity depends largely upon his ability to communicate with those around him. The individual who lacks this ability to communicate with others is regarded as odd or eccentric by his neighbors. Inability to communicate is one of the prime symptoms of mental illness. If this symptom is accompanied by any form of bizarre behavior the individual may very readily be classified as mentally ill, even by the untrained person, and committed to an institution.

It has often been said that more has been learned about mental illness in the last ten years than in the last century. Nevertheless, much research remains to be done in this field. Psychoanalysis, which might provide an insight into the patient's personality, is available to only a select few, and there is some question as to its value with psychotics. Actually all the hospital can do is treat the patient's symptoms. If these can be modified to the extent that the individual is no longer a threat to himself or the community, the hospital has accomplished its purpose and the patient is ready to be released. This does not mean that treatment is complete or that this is all that can be done for the patient. The patient released to the community on trial visit is still convalescing and needs much support.

The minimum hospital support available to such an individual has been described. If the hospital were to fully treat a patient, however, it would literally have to transform itself into a community. In those instances in which the hospital has attempted to provide the in-patient with facsimiles of community resources, it has been found that many a patient has adjusted fairly well to hospital routine. Thus if we expect the hospital to be completely responsible for the patient's treatment, hospitals would require more facilities, more personnel and, of course, fewer patients than are now lodged in most of our state institutions.

The more practical approach is to view the problem as it now exists. The hospital, with its limited staff and facilities, must devote most of its time and energy to caring for the in-patient population. As for the patient on trial visit, the hospital must turn to the community and encourage the use of all its possible resources in aiding the patient in the continuation of his treatment program.

Within recent years the community has been growing more aware of the fact that it, too, has an interest in the well-being of the patient on trial visit. The mass communications media have done much to educate the public in the broad field of mental health. There is an increasing willingness on the part of the community to extend its services to the patient on trial visit, and close working relationships have been established with vocational rehabilitation services and public assistance agencies. Nursing homes, boarding homes and even private families are showing signs of greater acceptance in providing care for the released patient through the family care programs instituted in many hospitals.

Case work agencies, too, are now more receptive to the patient's need for their services following his hospitalization. In the past these agencies had been reluctant to accept referrals from state hospital workers. They justified their reluctance to work with the families of patients with the statement that their primary function was to serve the community, thereby excluding the patient and his family as community members. It is much more likely that their unwillingness to work with patients and their families stemmed from a fear of and inexperience in working with psy-

chotics. Today case work agencies are much more cooperative in aiding the members of a patient's family. They have come to realize that the disabled family member cannot be neatly plucked out of his home and placed in a mental hospital without seriously affecting the remainder of the family group. The effect which the loss of a family member has upon the rest of the family, particularly children, is something that these agencies now realize cannot be shrugged off lightly as a responsibility of the state. Rather it is a task which they must share along with the state.

This same idea, once so prevalent in private case work agencies, that once a patient was committed to the hospital he was forever the responsibility of the state, was also a widely held concept among public assistance agencies. The legal procedure of commitment, although established for the protection of the patient, was often used to work against his best interests. This was particularly true in the case of elderly patients for whom inadequate facilities existed. The growing number of aged persons, along with the fact that there is a definite lag in the development of facilities for their care, creates a real problem.

It was under such circumstances that public assistance agencies only too readily avoided the responsibility of facing realistically the need for more adequate planning for these people by simply having them committed to a state hospital. Although this may have solved the agencies' problem, it did not solve the problem of the aged chronically ill. To bring about a closer cooperation between the hospital and these agencies a great deal of interpretation and discussion has been done, and today the understanding between the two is much closer.

Although social group work in hospitals has just recently come to the fore, there is much current discussion about the use of groups within this type of setting. Hopefully the more widespread use of group work with patients will extend outside the hospital and into the community. The need for such services is difficult to estimate but should be enormous.

For the last two years the writer has been the leader of a group of chronically ill trial visit patients. The purpose of this group, which meets weekly, is to provide a common meeting ground so that patients may come together to discuss their problems in an atmosphere of mutual trust and understanding. Since the inception of the group, about fifty patients have attended, 60% of them attending regularly during their trial visit period. The majority are chronic schizophrenics. Half of those in regular attendance have had two or more hospitalizations in state institutions prior to the one which led to their present trial visit status. Moreover, 40% of the regular members spent two years in the hospital on their last visit. For another 40% the length of their last hospitalization has been three or more years. In a 1951 study made by the psychology department it was shown that this type of patient had less chance of succeeding on trial visit than did the younger patient who had been hospitalized for the first time and had spent less than a year in the hospital.[2] It is significant, then, that none of the members of our group had to be returned to the hospital while they were in regular attendance at our meetings.

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[2] Toaru Ishiyama and Alexander Darbes, Report on the Trial Visit Population at Cleveland State Hospital (unpublished), 1951.

This group was begun by the writer with the aim of helping patients to help themselves in their struggle for adjustment in the community. During the first year the leadership of the group was shared with a hospital social group worker from whom I learned a great deal about the practical aspects of group work techniques. I became impressed with the value of providing group work services to aid the patient with one of his most serious problems, his interpersonal relationships.

The patient while on trial visit is living in the community; therefore the community must share the repsonsibility of helping the patient to adjust to it. If the patient's focus is to be on community integration and adjustment, it is preferable to have a community figure rather than a hospital figure assist the patient in his adjustment. To the patient, the community figure represents a link with the future while the hospital figure may represent a link with the past.

It is too much to expect that the chronically ill patient will seek community group work services on his own initiative. As a rule, group work agencies are unprepared to provide the kinds of services that the chronically ill patient needs. As did many case work agencies in the past, they consider it their primary function to provide service to the community, in general forgetting that the patient is also a member of the community. As case work agencies have become more willing to work with the mentally ill, so too must group work agencies.

Another factor favorable to the idea of having community group workers provide services for trial visit patients should be mentioned. The community group worker belonging to a settlement house or other type of group work agency not only has the necessary skills and training to work with trial visit patients, but he possesses also a thorough knowledge of the broader group work services of his agency. We have found that it is vital to the patient's well-being while on trial visit for him to form a satisfying relationship with one person who can aid and advise him in his adjustment. I believe that the patients in the trial visit group referred to earlier have been able to stay out of the hospital longer than is customary for this type of chronically ill patient largely due to the constant contact, support and understanding which was given them through our weekly meeting. How much better it would have been for the patient if this relationship had been formed with a community group worker! The patient's progress in a community center might be more easily brought about since the group worker would be in a position to help the more nearly recovered patients move out of the trial visit group and into other more socialized groups within the same agency. Thus the community group worker through his identity with his agency has an important advantage over the hospital case worker who can only refer his patients to community agencies and then let the patient proceed on his own.

The task of encouraging the community group work agencies to establish groups and activities geared to the interests of the trial visit patient belongs to the hospital social workers. It is they who must provide the initiative. Before they can progress far in this direction the hospital must first examine itself to see if it is still clinging to some old and traditional concepts in attempting to be all things to all people. If the hospital is to be a treatment center and not the end of the road for its patients it must not be content with meeting their

minimal needs but must look beyond its confines toward broader community participation.

The importance of providing community services for the mentally ill has been commented upon by Dr. Daniel Blain: "This factor of what can be accomplished outside the mental hospital is the most important single thing we should study and carry to its most logical conclusion."[3] He went on to point out that when community services are available many patients can be released sooner than would otherwise be possible and many of these might never have to return to the hospital again.

The trial visit patient, then, presents a real challenge to community participation. We hospital social workers must show the way. When this happens and the community responds to our call, the trial visit patient will then, indeed, find it easier to bridge the gap between hospital and community life.

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[3] Daniel Blain, "Mental Health and Illness—the National Picture," *Mental Hygiene*, 40(January 1956), 6.

MARY B. PALMER

Social rehabilitation for mental patients

For many patients the day of discharge from a mental hospital is not a joyous homecoming but the beginning of an isolation more complete than that in the hospital they have left. Although they may find jobs, at the end of the day they have no social life. Too many seclude themselves in rented rooms, and live alone, afraid, and sometimes ashamed. Others may confine themselves to the tight family group in which they originally fell ill. They do not know how to go about making friends nor where to look for them. Agencies and clubs in the community exist, but they cannot bring themselves to join.

To meet the need of this kind of patient, clubs for ex-patients have been springing up all over the country in the last few years. (Some also specialize in out-patients or include them as members.) A recent survey [1] reveals at least 24 independent groups, plus Recovery Incorporated with its headquarters in Chicago and some 180 loosely affiliated branches in 20 states. The independent clubs are variously sponsored by the hospitals themselves, mental health associations or state mental health departments or, occasionally, by ex-patients on their own. Although some clubs include therapy groups, vocational help and mental health education for both their members and the public, most focus on recreation. The club becomes the place to meet people, to learn to dance or try a new craft, to set off for a picnic or the local bowling alley. It offers members a chance to develop social confidence in company with

[1] The rehabilitation project at the Massachusetts Mental Health Center in Boston under the direction of Dr. Milton Greenblatt, assistant superintendent and research director.

others who have similar problems in an environment where they will not be shunned, ridiculed or pitied.

But the club movement is young and rather fragile. Average attendance at meetings seems to range from only 10 to 50, with most clubs somewhere in between. Some have started up only to fade again in a year or two. No national organization exists comparable to Alcoholics Anonymous, although Recovery Incorporated, which goes beyond socialization to offer a kind of self-help system somewhat similar to A.A., appears to be growing steadily.

Apparently mental illness has not yet achieved the social acceptance of alcoholism. There is still fear, folklore and stigma attached to it, especially when it includes hospitalization.

Secondly, mental illness includes a wide range of symptoms in people of diverse personalities. The alcoholic shares drinking as a common symptom with all other alcoholics. Even the epileptic can find affinity with others in his "league." But the mentally and emotionally ill have no specific habit or physical symptom to focus on together. Moreover, the degree of illness and the extent to which it permeates the whole personality differ. And some patients who are among the most isolated do not consider themselves as ill at all.

Finally, many discharged patients want to forget their hospital experience as quickly as they can, or are under pressure to do so from family and friends.

For all these reasons, clubs for mental patients usually adopt ambiguous or innocuous names. Unlike Alcoholics Anonymous, which blatantly announces its membership in its very name, these clubs hide behind such titles as Friendship or Beacon or 103. Even Recovery is not precise as to what its members are recovering from. Social Renascence in Columbus and Fight Against Fears in Chicago are only slightly more explicit.

In England, where the club movement seems to be more firmly entrenched, the generic term is more realistic: "therapeutic social clubs." At least 40 of them exist today, attached to mental hospitals as part of their after-care program. That they are taken seriously seems to be proved by the number in which a psychiatrist attends as adviser even when meetings are held after working hours. Dr. Joshua Bierer, director of the Marlborough Day Hospital (which alone has 9 clubs), believes that the patient's participation in a social therapeutic club can bring on real changes in his personality—even without conscious insight. Dr. Maxwell Jones of the Belmont Hospital social rehabilitation unit rarely misses a Wednesday evening club meeting of the "graduates" from his largely psychopathic "therapeutic community."

Few American clubs have psychiatrists as closely associated with them as in England, nor such enthusiastic medical backing. Most of the independent clubs have social workers as advisers. The Resthaven Recovery Group in Los Angeles is led by a psychiatrist but this is not so much a social as an educational organization with lectures and movies in mental health. Dr. Melvin F. Blaurock, Chicago neuropsychiatrist, started Fight Against Fears about two years ago, but he and his assistants are only occasional visitors to the club, which otherwise runs under it own steam. The Out-Patient Club at the Menninger Clinic in Topeka has firm clinic backing and employs a social group worker as adviser but encourages the member-officers to plan and organize their own programs as much as possible. Their dances, play-readings and game nights are popular, and members

have even put on a skit panning their own propensity for boasting about their symptoms.

In fact, most clubs in this country emphasize self-government and individual responsibility. While the English sometimes express misgivings that too much autonomy may lead to dictatorship by an aggressive minority, most American clubs seem willing to take the chance. A more frequent complaint heard here is that no one emerges in the club with any leadership ability, or that the more capable members leave as they have less need for the club.

Club 103 in Boston is an example of the self-government theory in action. Taking its name from its original street address, the club serves discharged patients from the Massachusetts Mental Health Center (formerly Boston Psychopathic Hospital) from which it draws official support. It originated as the natural sequel to patient government in the hospital. A social worker and psychiatrist are joint advisers to the club, but hospital policy is to encourage the ex-patient members to run their own affairs, without any staff at meetings. Although club fortunes have consequently varied with the leadership, there is a solid core of devoted and enthusiastic members. One young woman member recently put it this way: "The club has given me confidence in facing people. Going to parties here gave me courage to try on the 'outside.'" The club is thought of as a transition between hospital and community, although members may continue to come to meetings as long as they wish. Two ex-patients worked with the staff to start the club. One of these continues with the club, although she no longer holds office, seeing her work as a contribution to mental health.

Fountain House in New York City is probably the best known of the clubs, although it has branched out now to include pre-vocational training, job counseling and group therapy. Started by ex-patients and volunteers, it is now directed by a full-time social worker and psychologist. While most clubs meet in church parlors or the Y, this organization has its own 4-story house on the West Side. Its namesake in Philadelphia is newer and smaller, but also can claim its own quarters. Now carrying on a big public education program with good community backing, it started originally as the single-handed effort of a briefly hospitalized former school teacher.

Recovery Unlimited in Lincoln, Neb., was founded in 1953 by three former patients of the Nebraska State Hospital, one of whom had been hospitalized 18 years. Members now hire a clinical psychologist one evening a week to moderate—but not direct—discussions. At other meetings the general public has been invited in, and the program chairman reports healthy support and interest.

SEARCH is another autonomous club. It originated in a pinochle game in which two ex-patients joked about starting an organization for "crackpots." The president, a patient at Binghamton State Hospital for 19 months, has recently left the club in other hands to devote himself to publishing a mimeographed newsletter of interest to ex-patients across the country. It contains news of club activities, problems of patients in adjusting to life outside the hospital, and a sturdy correspondence from interested people, including professionals. The publication is also called SEARCH.

Recovery Incorporated is more therapeutic than social in intent and uses a system in some ways similar to A.A. Started in 1937 by Chicago neuropsychiatrist Dr.

Abraham Low for his own patients, the organization has carried on without medical leadership since his death in 1954.

Recovery meetings are directed by persons who have themselves been mentally or emotionally ill. The leader selects a panel of members each week to discuss the meaning to each individual of one of the chapters in Dr. Low's book *Mental Health through Will Training.* Focus is on everyday experiences and the futility of sick behavior, somewhat reminiscent of the "educational" approach of the late Dr. Austin Riggs of Stockbridge, Mass. Accent is on success, and both leader and group praise the member who has made a step forward.

For example, at a recent meeting in Baltimore, an immigrant woman proudly described her persistence in hunting for work even after being turned down three times. Before joining Recovery a few months before, she said, she would have crawled home to bed to sob to herself that she was persecuted for being "foreign." A factory foreman told how he overcame a crippling resentment toward a newly-hired college boy. At another club, in Stamford, Conn., a storekeeper compared Recovery to "going to school again—only here you graduate when you're ready."

This latter group in Stamford was initiated through the efforts of Dr. Stanley R. Dean, a local psychiatrist, who interested one of his private patients in organizing it, plus a group in Greenwich. He sees Recovery as offering the patient an opportunity to help himself, to give service to others and to have a group experience. He believes it is a very useful adjunct to psychotherapy, and no more of a rival to therapy than church work or service in a useful civic organization. Members of the two clubs include both neurotics and psychotics in remission.

Some clubs for ex-patients invite relatives, and occasionally friends, to visit or actually to join. From this source an English psychiatrist has reported acquiring new patients who might never have sought professional help, or only in the later, and tougher, stage of their illness. The Canadian Mental Health Association in Saskatchewan now operates a rehabilitation center in which both ex-patients and their relatives are active. They have a carefully planned and professionally directed program. The Mental Health Association in Tucson, Ariz., has only married couples in its Friendship Club.

Carrying the club idea a step further are the "half-way houses" in which ex-patients without suitable homes can live until they are ready to establish a place of their own. Usually they are expected to take jobs in the community, but policies are flexible and periods of unemployment tolerated. Three such hostels now are fairly well established in this country. They are Portals House in San Francisco (for male veterans), Rutland Corner House in Boston (for women from the Mental Health Center), and a house for women patients from the Vermont State Hospital sponsored by the Division of Vocational Rehabilitation. In England, the S.O.S. Society runs such an organization for discharged male patients and includes vocational training, while the Marlborough Day Hospital is experimenting with a patient-operated hostel on a small scale. Many mental hospitals in both countries have shown great interest in developing the idea further.

The question naturally arises as to which kinds of patients benefit most from social therapeutic clubs in all their variations, and just how much of a contribution such clubs can make. There has been no definitive research on this, although the Fel-

lowship Club in San Francisco has a special research grant to study the whole question. All that is known now is that existing clubs serve almost every diagnostic category among both neurotic and formerly psychotic patients.

Isolation and loneliness are common in the mentally and emotionally ill. The therapeutic social club in all its variations from recreation to "will-training" offers social rehabilitation, strengthening of self-confidence and an opportunity for responsibility and service. As the movement grows, perhaps members will, in their turn, "rehabilitate" the general public in its outmoded attitude toward mental illness.

MARJORIE P. LINDER, M.Ed.
DAVID LANDY, Ph.D.

Post-discharge experience and vocational rehabilitation needs of psychiatric patients

In November 1955 the Massachusetts Mental Health Center received a grant from the Office of Vocational Rehabilitation, Department of Health, Education and Welfare, to conduct a "project for research and demonstration of the value of combined hospital-patient-community participation in rehabilitation of the mentally ill." Prior to this the hospital, very much aware of its desirability, had maintained a loosely coordinated network of rehabilitation services (2), but with the beginning of the project a formalization of the rehabilitation process was begun. The present research was designed to study a group of ex-patients to determine (a) the vocational assistance needed by the emotionally handicapped at the time of discharge and after, (b) the post-discharge vocational experiences of former patients, and (c) the vocational assistance derived from a hospital rehabilitation program. The third objective will be only briefly considered in the present study, but it is planned to cover this area more fully in the near future.

Grateful acknowledgment is made to the Office of Vocational Rehabilitation, U. S. Department of Health, Education and Welfare, under whose grant (No. 36-57-C1) for a research and demonstration project, "Rehabilitation of the Mentally Ill," at the Massachusetts Mental Health Center (Boston Psychopathic Hospital), this study was done. Gratitude is also expressed to the project's principal investigators, Milton Greenblatt, M.D., Robert W. Hyde, M.D., and J. Sanbourne Bockoven, M.D.; to the hospital's superintendent, Harry C. Solomon, M.D., and to Anne Ogilby, of the hospital's social staff, for helpful criticisms and suggestions.

Miss Linder is a research assistant on the rehabilitation project at the Massachusetts Mental Health Center and recipient of a rehabilitation counseling grant from the Office of Vocational Rehabilitation, at Boston University. Dr. Landy is research anthropologist on the project and a research associate in the department of psychiatry of Harvard Medical School.

Work opportunities for the emotionally and mentally handicapped became of national concern when in 1943 the Barden-LaFollette Act was modified to include the mentally handicapped on the same basis as the physically handicapped in state rehabilitation programs. In the United States many studies of the effects of stresses produced by the second world war on the military and civilian populations, together with the startling reports of large numbers of Selective Service rejections because of neuropsychiatric disabilities, served to sharpen the awareness of the enormity of the mental health problem. The growing interest and concern resulting from this recent awareness has found its focal point in the concept of rehabilitation. The National Council of Rehabilitation defines the word as "the restoration of the handicapped to the fullest physical, mental, social, vocational and economic usefulness of which they are capable."

In an industrial society where the measure of success and achievement is "the job," vocational rehabilitation is a cornerstone. As Thomas A. C. Rennie of Cornell University Medical School said, "Among the many stresses that beset modern man an important one certainly surrounds his job aspirations, level of training for vocational role, strivings for upward social and economic mobility, conscious and unconscious attitudes towards those in superior or inferior status around him, and his characteristic modes of interpersonal reaction with all persons including those with whom he works" (3).

Rehabilitation is the process of assisting the individual to attain independence and employability within the range of his own physical, emotional, social and intellectual capabilities. As Rennie, Burling and Woodward view it, vocational rehabilitation is concerned with the employability of the individual within this definition and offers five services for the mental patient: (a) vocational counseling, (b) vocational training, (c) psychiatric restoration, (d) job finding and placement, (e) personal counseling and follow-up throughout the rehabilitation process (4).

It has become increasingly apparent that it is not enough for a patient to be "treated" and "cured"; at the same time there must be what Howard Rusk calls "the third phase of medicine"—rehabilitation. This is a vital part of the process of overcoming loneliness and anxiety, of relating to reality, of gaining in self-esteem and self-confidence and of becoming motivated. Many times the job itself contributed to the emotional upset; at other times the hospitalization and resulting loss of self-assurance have made returning to work a seemingly insurmountable barrier.

Research in vocational rehabilitation of psychiatric patients has been of a limited and pioneering nature. In 1947 the division of rehabilitation of the National Committee for Mental Hygiene made a survey of the vocational needs and opportunities of post-hospitalized patients in three states: New York, Connecticut and Michigan (4). The results showed that of 2,653 convalescent or discharged patients included in the study 215 or 15% were classified as needing rehabilitation and feasible for the rehabilitation bureaus' standards. Of these, 166 were successfully rehabilitated (satisfactorily employed at the time the case was closed) and 49 were closed as not rehabilitated. There were found to be few significant differences between the rehabilitated and non-rehabilitated as to clinical diagnosis, age, education and other factors. Within the framework of the five services comprising vocational rehabilitation, it was

found that "vocational counseling is given more extensively than any other service in all states and in almost 100% of the cases in New York State" (4). In addition, job finding was found to be the second most extensive service and vocational training was third.

The importance of vocational rehabilitation was also underlined by a study of the social adjustment of patients three years after commitment to the Massachusetts Mental Health Center (1). Of the 106 patients included in the study 80% were found to be working at the 3-year follow-up point and there was evidence that "work relations were more a satisfaction than a stress and that other community relations were more stress than satisfaction" (1).

These two studies further emphasize the importance of work in the total readjustment and reintegration of the emotionally handicapped and the need for vocational rehabilitation. In accepting this fact it becomes equally important to determine the vocational rehabilitation needs not being met. An incisive paper by Unterberger and Olshansky (5) led us to predict that vocational counseling would be a most important need.

METHOD AND SAMPLE

It was decided to focus on the five major service areas comprising vocational rehabilitation. A personal interview with direct questions, but administered open-end fashion to permit elaboration by the respondent, was chosen to avoid the lack of accuracy and low returns common in the use of mailed questionnaires. The interview was pre-tested with two groups under "realistic" conditions. One group of 11 was composed of the working members of 103 Club, the ex-patients' organization of the hospital. The other included 6 members of the hospital team: doctor, social worker, nurse, attendant, occupational and physical therapists. Each pre-test interviewee was asked for criticisms and suggestions and several revisions were made on the basis of these trials.

The total male[1] discharges or tranfers from January through June 1955, excluding court cases and all others on a 10-day observation basis, totaled 90. Of these, 18 were transferred to other hospitals, 5 had moved out of Massachusetts, 4 had been sent to correctional institutions, and 3 were over 65. One patient had joined the navy and 3 more were too disturbed to be contacted, according to their physicians.

This left a group of 56 patients to be interviewed. Original contacts were made by telephone and interviews were arranged either at the hospital or at home if the individual refused to come to the hospital or was limited as to time. A total of 28 patients were interviewed personally at home or at the hospital. Three who refused a personal interview after repeated attempts agreed to a telephone interview. Two could not be located at all. This left a group of 23 who could not be reached personally. All of these were mailed a mimeographed questionnaire with a stamped, addressed envelope. After the questionnaire was followed up with another letter, 3 refused either personally or through an intermediary to return them and 11 did not respond at all. The remaining 9 returned the questionnaire. Thus the total sample consisted of 40 male ex-patients, which compares closely with the

[1] Male patients were selected because they have more job possibilities and experiences than females, and are much more often cast in the role of breadwinner.

74% effective sample of Bockoven, Pandiscio and Solomon's study (1).

There was a variation of 45 to 120 minutes in interview time, a result of the amount of responsiveness and variation of post-discharge occupational experience, the difficulty or ease with which the person could recall information and express himself, his interest in the survey itself, and the individual's need to talk. Many treated the interview in part as a therapy session—a chance to "let off steam" and speak freely.

FURTHER LIMITATIONS

Only male patients hospitalized 11 days or more were included to eliminate court cases. In addition, patients were excluded who were either readmitted or discharged from the hospital after June 30, 1955. This was done so that everyone in the sample would have had a minimum of one year out of the hospital and the possibility of a year's work experience.

The fact that there are two kinds of discharges—"outright" and "from visit"—presented an additional limitation. Those patients discharged "outright" (half the sample) left the hospital on the date of discharge. Those discharged "from visit" left the hospital one year before the final date of discharge and were at home but "on trial visit." In some cases this time was shorter owing to circumstances requiring an immediate discharge such as getting a driver's license or personnel policies requiring a final discharge before employment. These discrepancies in discharge dates resulted in considerable differences in the length of period out of the hospital, although the longest time possible was 2½ years.

The age ceiling for the study was set at 65 years because of the vocational emphasis. This age limit ignores the problems of geriatrics, an important concern of rehabilitation, but this was done in an effort to keep within the recognized retirement age.

REHABILITATION NEEDS AND EXPERIENCE OF THE SAMPLE

The sample ranged in age from 19 to 65, the mean age being 34.7 and the median also falling between 34 and 35 (see Table III). Educationally the group divided as follows: the majority, 24, had 12 years or less of schooling; one-fourth, 10, had three years or less of college, and the remainder, 6, held bachelor's or master's degrees. Nearly half, 19, had received some type of special vocational training, including graduate college careers (see Table IV).

At the time of the study 75% of the group were working, quite comparable to the 80% found working three years after commitment in the somewhat larger sample from the same hospital of Bockoven, Pandiscio and Solomon (1). Of this proportion, 1 was retired, 2 had not worked since discharge, and 5 had had several jobs of short duration.

Let us first relate the various diagnostic categories with the post-discharge occupational histories (Table I). It is apparent that schizophrenic psychoses accounted for more than half the cases, which is not untypical of the populations of most psychiatric hospitals. If we compare the number of jobs held by diagnosed schizophrenics with those held by patients labeled with one of the affective psychoses, we find that there is a marked, although not statistically significant, tendency for affective psychotics to have less vocational fluctuation in the post-hospital period, with a 7 to 0 ratio in favor of fewer than 4 jobs compared with a 3 to 1 ratio for schizophrenics.

TABLE I

Diagnosis and number of jobs held after discharge between 1 and 2½ years for 40 male ex-patients of the Massachusetts Mental Health Center

DIAGNOSIS	NUMBER OF JOBS HELD					TOTAL
	None	*1 Only*	*2–3*	*4–5*	*6 Plus*	
Schizophrenic psychoses	2	5	10	2	4	23
Affective psychoses	1[a]	6	1	–	–	8
Psychoneuroses	–	3	1	1	–	5
Mental deficiency with psychosis	–	–	1	–	1	2
Organic: brain syndrome	–	–	1	1	–	2
					Total	40

[a] Retired

Furthermore, if affective psychoses are combined with psychoneuroses, the difference from schizophrenics in having fewer job changes becomes highly significant ($.01 > p > .005$).[2]

It is also to be noted that only one of the affective psychotics held no positions after discharge; this was a post office worker who had held the same position for 30 years and retired because of a physical disability. Among the psychoneurotic group not a single one remained unemployed after discharge. On the other hand, among the schizophrenics 2 did nothing at all vocationally upon discharge and more than a third, 8, had to take jobs in completely new types of work; not a single one of the affective or psychoneurotic patients had to go into a new field of endeavor. These findings seem to confirm the conclusions of Rennie, Burling and Woodward (4): "The largest group who need and can profit by vocational rehabilitation services are those whose illness occurred so early in their lives that they had not had time to become established vocationally, or even take adequate vocational training. Most of these are schizophrenics, some of whom

[2] For this and all other tests of significance which follow, we used a common splitting point (in this case, 1–3 jobs and 4 or more jobs held) and utilized a chi-square test for the dichotomized variables, corrected for continuity, where N was 31 or more, using the formula for chi-square with Yates' correction:

$$\chi^2 = \frac{(|ad-bc| - N/2)^2 N}{(a+b)(a+c)(b+d)(c+d)}$$

where a four-cell contingency table with one degree of freedom is arranged as follows:

a	b	a+b
c	d	c+d
a+c	b+d	N

(See H. M. Walker and Joseph Lev, *Statistical Inference*. New York, Henry Holt and Co., 1953, 100–108).

For instances where N was 30 or less and the marginal sums met the requirements, the tables for Fisher's exact test were used (see D. J. Finney, "The Fisher-Yates Test of Significance in 2 x 2 Contingency Tables," *Biometrika*, 35(June 1948). Acceptable significance was set at the .05 level.

break down before they have completed their education or have had work experience. . . . The attitude of employers toward them is very different from that toward workers who have been well-established."

It should be remarked, however, that generally the preponderant number of patients in all types of diagnoses tended to hold fewer rather than more jobs when they left the institution. Furthermore, of those who held 4 or more jobs, 3 were by occupational training and experience workers like plasterers and painters who usually go from one job to another as construction projects are completed and thus routinely would hold several employments in any long period. One who was diagnosed as a mental deficient expectably would be qualified for temporary and unskilled employment only. In this case the ex-patient's occupations were confined to such menial tasks as car polishing, lawn mowing and dishwashing. Thus it is possible that the occupational careers of ex-patients of psychiatric hospitals do not differ appreciably, insofar as employment variation is concerned, from those of a comparable group who had not been hospitalized, although unfortunately we do not have such a control group for comparison.

There is little difference statistically between being older or younger than 35 years and the number of jobs held (Table II). In either case there is a trend of about 3 to 1 in favor of both age groups holding fewer, rather than more, jobs. However, when the half of the sample below the

TABLE II

Age and number of jobs held after discharge between 1 and 2½ years for 40 male ex-patients of the Massachusetts Mental Health Center

AGE	NUMBER OF JOBS HELD					
	None	*1 Only*	*2–3*	*4–5*	*6 Plus*	TOTAL
15–19	–	–	1	–	1	2
20–24	1	–	3	2	2	8
25–29	–	5	2	–	–	7
30–34	–	–	2	–	1	3
35–39	–	2	2	–	1	5
40–44	1	3	2	1	–	7
45–49	–	–	1	–	–	1
50–54	–	–	1	1	–	2
55–59	–	1	–	–	–	1
60–64	1[a]	2	–	–	–	3
65–69	–	1	–	–	–	1
					Total	40

[a] Retired

TABLE III

Age, marital status and status of responsibility for others of 40 male ex-patients of the Massachusetts Mental Health Center

AGE	MARITAL STATUS				TOTAL
	Single	*Married*	*Separated*	*Divorced*	
15–19	2([b])	–	–	–	2
20–24	6	1	–	–	7
25–29	7([a]; 1[b]; 2[c])	1	–	–	8
30–34	2	–	–	1[a]	3
35–39	2	1	1	1[a]	5
40–44	4([a])	3([b])	–	–	7
45–49	1[b]	1	–	–	2
50–54	–	1[b]	–	–	1
55–59	–	1	–	–	1
60–64	1	2	–	–	3
65–70	–	1	–	–	1
				Total	40

[a] Has dependents, although single or divorced, and is self-supporting.

[b] Has dependents, but currently is unemployed and supported by wife or parent.

[c] Has no dependents, but is not self-supporting.

median age is dichotomized into those less than 25 and those from 25 through 34 years, the latter group has a significantly higher probability ($.02 > p > .01$) of having less job variation, so that for the very young subgroup greater "job-hopping" may be a function of youthfulness. How this fact may be related to the need of younger men to experiment with various occupational roles and situations until "settling down in a groove" we can only surmise, but some such association seems likely. It is probably more than coincidence that nearly a third of the schizophrenic group are in this youngest subgroup; none of the affectives is in this group. In fact, about two-thirds of all the schizophrenics are below the median age, but only one of the affective psychotics is in this age group. The patients classed as psychoneurotic distribute themselves about evenly throughout the age spread of the sample.

However, age is not the only criterion of vocational mobility. Obviously the degree of freedom with which a person is able to change positions, to utilize freedom of movement, depends to a large extent upon his responsibilities toward others for support. Marital status may be taken as a partial index of this factor (see Table III).

Excluding the three separated or divorced men, the single men, as might be expected, tend significantly ($.01 > p > .005$) to fall in the age below the median. But there is little difference between the incidence

of single and married men as to whether they are self-supporting, the former tending in a 5 to 1, the latter in a 6 to 1 ratio. This is another finding which may lead one to infer that, so far as freedom from dependence upon others for financial support is concerned, the vocational rehabilitation potential of former psychiatric patients is relatively high. Both divorced men had dependents and were self-supporting. Finally, the fact that most single men are below 35 years of age indicates again that the older age group has the most social responsibilities and therefore the least freedom of job movement. But it should also be remarked that there is no significant association between marital status and the number of jobs held after discharge from the hospital.

Among our sample there is no appreciable difference between those having an education of 12 school grades or less (see Table IV) and those having some college education as to the number of jobs held. Those with up through a high school education held fewer jobs in a 3 to 1 ratio than those in the more highly educated group, who held fewer jobs in a 2 to 1 ratio. Subdividing the school-educated group, we also find no statistical difference between those having a 6th to 9th grade background and those with a 10th through 12th grade education, although there is some tendency for the latter group to have proportionately less vocational variability.

While the difference is not significant, there is a marked tendency for those with an incompleted university career to hold fewer or more jobs in about equal proportions, while those who completed their college curricula tend strongly to have fewer employment changes. This latter group is occupationally the least changeable of all the educational categories.

There is a marked trend, barely short of significance, for those with special train-

TABLE IV

Education, special training and number of jobs held after discharge between 1 and 2½ years for 40 male ex-patients of the Massachusetts Mental Health Center

	NUMBER OF JOBS HELD					
EDUCATION	*None*	*1 Only*	*2–3*	*4–5*	*6 Plus*	TOTAL
6th–9th grades	1[a]	4	4(2[b])	2[b]	1	12
10th–12th grades	–	4(2[b])	8(4[b])	–	1[b]	13
Up to 3 years of college	1	2(1[b])	1[b]	2[b]	3[b]	9
College graduate and/or graduate training	1[b]	4[b]	1[b]	–	–	6
					Total	40

[a] Retired

[b] Special vocational training and/or specialized graduate training, e.g., graduate degrees in divinity, pharmacy, etc.

TABLE V

What 40 male ex-patients of the Massachusetts Mental Health Center did compared with what they wanted to do regarding pre-hospital occupation

WHAT THEY DID	WHAT THEY WANTED TO DO	TOTAL
Returned to same job	What they did	13
	Receive training and/or counseling toward different job	6
	"Nothing"	1
Different job, same field	What they did	2
	Receive training and/or counseling toward different job	3
	Return to old job	1
Different job, different field	What they did	1
	Receive training and/or counseling toward different job	10
"Nothing"	"Nothing"	2
Retired	What they did	1
	Total	40

ing to hold fewer or more jobs in roughly equal proportions, while those without special vocational training hold fewer jobs in a 6 to 1 proportion. If we consider only those with a high school education or less, the same tendency continues, those without special training holding fewer jobs. Roughly the same tendencies exist within the 6th to 9th grade group and the 10th to 12th grade group.

Thus, on the face of the data, vocational training other than that gained through on-the-job experience seems to result in somewhat greater, rather than less, employment variability. One should not necessarily infer from this fact, however, that special training constitutes an obstacle to job "stability." It may also mean that more employment opportunities are available to those with special skills and therefore they can afford to shop around more in the vocational market until they discover socially as well as occupationally congenial work situations.

It is important at this point to discuss briefly the emphasis devoted here to another variable, the number of post-discharge jobs. It might be possible to use this factor as an index of rehabilitation adjustment if we are clear as to what is meant by "adjustment" and probe some of the implications of such a definition. However, it seems obvious that while in some studies considerable importance is attached to the number of jobs held as an index of "good" or "poor" work history, this variable has

little meaning when used alone and may even lead to distorted evaluation of the ex-patient's rehabilitation potential.

Of what significance is it to call a patient who sticks to the same job "stable" while labeling as "unstable" or "poorly adjusted" one who, in the post-hospital experience, casts about in the occupational world until he is able to test that world, discover his own capabilities, and arrive perhaps at a finally satisfying and congenial occupation? We do not always have direct evidence that this is in fact the case with those in the sample who held several jobs, although from the facts cited in this section such a possibility definitely exists. It is not without significance, for example, that of the 30 in the sample working at the time of the study, 26 expressed satisfaction with their current employment.

This is not to say that number of jobs may not be a partial indicator of adjustment or "stability" (disregarding the whole complicated question of whether and under what conditions "stability" is even desirable from the individual ex-patient's point of view), but only that the individual case must be examined before final conclusions are drawn. Some confirmation for this assertion is found in Table V. Of the 20 men who returned to the same job held prior to hospitalization, 6 wanted training and/or counseling toward preparation for a change in career. Of the total of 37 who had worked at some time between discharge and the time of the study, more than half, 19, preferred preparation for something other than what they were doing.

But the more positive needs and attitudes of these ex-patients must also be considered. If we compare those who resumed their old positions with those who took new positions though in the same type of employment, we find a definite tendency, just lacking statistical significance, between returning to the same job and the desire to do this. That is, most of those who returned to their pre-hospital positions wanted to do this, while those who took different jobs in the same field more often wanted either to return to their old jobs or receive training and/or counseling toward a change of occupation.

If we combine the above groups—all those who returned to the same occupational field—and compare them with those who had to go to a different field and job, we find a significant difference ($.02 > p > .01$), showing that those who had to try new avenues of employment wanted a change of some kind (see Table V).

Now, if we dichotomize these last two groups according to whether they had special occupational training, we discover a decided, although not significant, tendency for those who had special training to return to their same field (a 4 to 1 proportion), as compared with almost equal proportions in the category of those without special skills. Thus extra training may be expected to provide some assurance of returning to the pre-hospital type of employment.

For the occupational situation just prior to hospitalization, the range of number of places of employment applied to was 1 to 12, with a mean of 2.9 and a median of 1.0. Thus, slightly more than half applied only once. For the first job after discharge the range of applications was 1 to 30, with a mean of 5.0 and a median of 1.0. For the second job after discharge the range of applications was 1 to 18 with a mean of 4.3 and a median of 2.5. For the third job after discharge the range was 1 to 17 with a mean of 5.7 and a median of 5.0. While these employment-seeking experiences indicate a surprising degree of perseverance by

this group of former mental patients, it is also apparent that for those who did have more than one post-discharge employment, the difficulty of obtaining a job seems to have increased. In part this is a function of the individuals who moved from job to job, including those who, as earlier stated, usually had seasonal or short-term employment.

On the first job after discharge, 13 of the former patients told their employers of their hospitalization; 4 of these were 1-job holders. Added to those who volunteered this information were 9 whose employers were previously aware of the fact; 6 of this group were 1-job holders. Therefore, a total of 22 employers on the first post-discharge job knew they were hiring former psychiatric patients. However, on the second job only 7 ex-patients informed their employers of this fact; of these 4 had also done the same for the first post-discharge employer. By the time of a third job, for those who had 3 or more jobs, only 3 men told their employers they had been patients, and of these 2 had done the same for both previous employments. Undoubtedly the fact that such men had already had one or more post-discharge positions meant there was no longer any need to explain their hospitalization, especially with these previous employments as recommendations. But there is also the probability that some employers did not look with favor on former patients, and telling them proved a real disadvantage. Our experience in the hospital leads us to feel that the psychiatric patient generally seems to prefer to apply for a job on his merits and considers himself under a handicap when his illness is known by the employer, except perhaps in those cases where the employer already is aware of his status as a former patient.

For the job held just prior to admission to the hospital, the weekly salary scale for those men, 36, supplying this information ranged from $7.50 to $115, with a mean of $55.10 per week. The salary range for the first job after discharge was $10 to $115 per week, with a mean of $57.93. For the job held by those working at the time of the study, the weekly wage varied from $14 to $120, with a mean of $59.19. While being in the hospital resulted in economic dislocation for some of these men, especially those who did not find immediate employment or took a job at a wage lower than the one held before entering the hospital, it can be seen that on the average being in the hospital does not seriously affect the wage-earning capabilities of psychiatric patients. Indeed, for those who did obtain work the average salary was slightly higher.[8] In fact, for many being in the hospital may actually have increased their earning power, since crucial psychological problems for some men found some measure of solution.

Reasons for leaving various post-discharge positions were reported for 64 jobs. A total of 20 were layoffs owing to the jobs' being seasonal or otherwise of a temporary nature (construction, grass cutting, etc.). Nine were discharges because of changes in work force or because of requests for a change (such as more wages or some other modification of working conditions). Nine were changes for another position for some reason, predominantly because the new job was seen as better in some way. Working conditions led 14 to quit outright, 4 because of low salaries. Health was given as the reason for leaving 9 positions and "lack of interest" in 3 cases. In many of the cate-

[8] The increase in real wages, in a time of inflation, may have been nil. But what remains important is that no decrease in dollars and cents, on the average, occurred.

gories just cited the ex-patient admitted not being able to keep up with the demands of the job, especially regarding long hours or supervisors who were punitive or otherwise lacking in understanding.

SOURCES OF REHABILITATION ASSISTANCE

During the men's sojourn in the hospital, the activities which most helped to prepare them for returning to the vocational community were given in about the following order of frequency: social activities, ward duties, occupational therapy, physical therapy, patient government, kitchen duties, psychodrama. Seven of this group of former patients felt that none of the hospital activities promoted their vocational rehabilitation. Among the majority who did deem them helpful, however, most noted at least 2 of the activities just named.

Concerning assistance in obtaining work through specific individuals, 13 former patients claimed themselves as their only source; the following served as the only source for others: doctor, 2; friend, 4; social worker, 1; relative, 5; former employer, 4; occupational therapist, 1. The following were listed in combination: relative, doctor and self, 1; former employer and self, 2; self and minister, 1; doctor and relative, 1; doctor and friend, 1; doctor and occupational therapist, 2; friend and minister, 1; self and friend, 1. Thus, sources of assistance in preparing for and/or obtaining employment on leaving the hospital were diversified, with a third of the men feeling that perhaps their greatest help was derived through their own efforts.

Means through which these 40 male ex-patients obtained a total of 97 jobs within the period covered by the study are as follows: direct application by self, 29; friend, 26; private agency, 10; relative, 8; returned to job held open by former employer, 8; U. S. Employment Service, 5; State Division of Vocational Rehabilitation, 5; civil service, 3; union, 1; university, 1; church, 1. The large number of jobs obtained through direct application indicates that many of these former psychiatric patients had strong personal resources to meet the needs of self-maintenance. Even a larger number obtained employment through the intercession of relatives or friends, demonstrating the widespread willingness of many families and friends to assist the rehabilitation of the psychiatric patient and/or continuing dependency in these instances of the patient on those closely related to him.

Only 7 of these 40 former patients reported being still in psychotherapy at the time of the research: 3 see a psychiatrist once a week, 3 see a psychiatrist twice a week, and 1 sees a social worker once a week. Another is getting chemotherapy through a tranquilizing drug. The remaining 32 either felt no need for further therapy or none was arranged during the discharge process.

Of the 37 who worked at some time between discharge and the study, 32 felt their families approved of the type of work they were doing, 1 family disapproved, 3 were indifferent. One patient has no family.

The vocational fate of many of these ex-patients might have been altered had they received the kinds of rehabilitation services which the hospital, under its research and demonstration grant, has been able to set up. Two brief case summaries are given as examples of the kinds of challenges and duties imposed upon responsible rehabilitation personnel.

In the first case, it is apparent that this young man must be rendered rehabilitation services, since he has no means of fa-

milial support. R.B., age 19, was diagnosed as having mild mental deficiency. He entered school at 7 but was soon withdrawn owing to poor health. He was privately tutored after this. When R.B. was 13 his mother committed suicide and his father died several days later of a heart attack. Soon after this R.B. was hospitalized at a large state hospital near Boston. Upon release he was sent to a home for retarded children and from there to a foster home. At 18 he was sent to the Massachusetts Mental Health Center for "becoming increasingly destructive and dangerous to manage." His doctor reported that R.B. "is apt to get into serious difficulty if he is allowed to go on his own, or even continue as at present—unemployed and at loose ends." He has worked closely with a social worker but the emphasis has been on his home and social adjustment. In the interviewer's opinion R.B. needs vocational training accompanied by intensive counseling to enable him to increase his earning power and sustain himself.

In the second case, although this recently married ex-patient has made a kind of vocational "adjustment," further training and counseling services could conceivably assist him in attaining a higher level of work satisfaction. G.V., age 23, has been hospitalized twice, once at another hospital for 14½ months, and then transferred to the Massachusetts Mental Health Center for six months. He has always been interested in working with his hands. He had difficulty in school with reading and writing and left at the end of the 8th grade. He went to vocational training school for a year and a half but left because he felt he had "learned all he could" and was afraid to make mistakes in his school work. This fear of fulfilling responsibilities was again evident when he took a job as a cabinet maker but left when the employer wanted to make him an estimator. He then worked for a radio repair company and performed part-time radio repairs at home. This part-time work developed into a thriving business but was interrupted at his first hospitalization. Since his discharge he has had three jobs: one for a month, one for 14 months, and the third he still holds. He is working on an assembly line and feels he can get no further because of his lack of formal education. He says he is eager for further education and training.

SUMMARY

When the study was made 75% of the 40 male ex-patients of the Boston Psychopathic Hospital (Massachusetts Mental Health Center) were working, which compares closely with the 80% found working three years after commitment to the hospital in another study. Schizophrenic patients constituted more than half of the sample. There is a strong tendency for patients with affective psychoses or psychoneuroses to have less vocational fluctuation after leaving the hospital than schizophrenics, although as a group the sample tended to have fewer (1 to 3) rather than more (4 plus) job changes. And schizophrenics tended much more often to change completely the manner of their vocational livelihood than did patients with affective psychoses or psychoneuroses.

When divided at the age median of 35 years, there is no correlation between age and number of jobs held after discharge, but within the younger group those under 25 had significantly more job variation than those over that age. This is probably associated with the needs of the more youthful for some trial-and-error before settling into a vocational pattern, and also with the fact that most of the schizophrenic patients were in the below-median group.

Job variation is also related to the degree of freedom for changing jobs, and one index of this was thought to be marital status and whether or not the person had responsibilities for the welfare of others. However, no significant association was found between being single or married and the number of post-discharge positions held. And both groups tended by and large to be self-supporting. But age is significantly associated with marital status, again pointing up the greater responsibilities and lesser vocational freedom of the older men.

The only educational category differing markedly in number of jobs held was that of college graduate, this group holding fewer jobs or making fewer changes than any other group. In this regard there were only minor differences between having a high school, grammar school or incompleted college education.

At all educational levels, having special vocational training seems to make no difference in number of jobs held; in fact, there were more job changes with greater frequency of special skills.

Half of the men returned to the job from which they were originally hospitalized. Of the total who had worked at some time after discharge, more than half felt a need for training and/or vocational counseling toward a job change. Most of those who returned to their original jobs did not feel the need for more counseling and training, but most of those who took different jobs did feel this need, and the difference is highly significant. And having special training made a decided difference, at a 4 to 1 ratio, in whether the former patient returned to his original job.

For those with a multiple employment experience the difficulty of finding jobs did not seem to decrease; in fact, for those who had three or more jobs there was a general increase in number of applications made.

Nearly 25% of the total sample returned to work for employers who already knew of their illness and an additional 33% informed their employers on the first job after discharge that they had been mental patients. Thus, 58% of employers on the patients' first job after leaving the hospital knew of the psychiatric illness of these men, but this decreased considerably with succeeding jobs. Unexpectedly, there was a general mean increase in salary over the pre-hospital wage. Reasons given for leaving job ranked in about the following decreasing order of frequency: seasonal or temporary employment, working conditions and salaries, health, request for a raise or reduction in work force, and lack of interest.

The majority who felt they were helped toward rehabilitation through hospital activities named the following in decreasing order of frequency: social events, ward duties, occupational therapy, physical therapy, patient government, kitchen duties, psychodrama. The following individuals were most helpful toward rehabilitation: the patient's use of himself, doctor, friend, former employer, occupational therapist, minister and social worker. In order of frequency these means were used for obtaining employment: self, friend, private agency, relative, former employer, U. S. E. S., State D. V. R., civil service, university, union, church. About a fifth of the sample were still receiving therapy of some kind. Most who worked after discharge felt their family approved of the kind of employment.

CONCLUSIONS

That the majority of the 40 former male patients were working from one to 2½ years after leaving the psychiatric hospital seems to point up the probability that,

given methods of treatment currently in use and the present rate of relative economic prosperity, there is a good chance that the emotionally handicapped patient will be able to achieve some measure of successful vocational rehabilitation. Such an inference gives rise to the consideration of what the chances for vocational success would be in time of relative economic depression, since presumably work opportunities as well as sources of financial support for treatment and rehabilitation would be diminished. Perhaps such a possibility might be anticipated realistically in rehabilitation planning, especially at the state and federal levels.

The findings of the study also underline the need for vocational counseling and other rehabilitative services both in the hospitalized phase of the patient's life and afterward, as shown in the discrepancies between what these patients did after discharge and what they wanted to do (5). In general schizophrenics would seem, along with mental defectives, to require certain special consideration in vocational counseling and planning, especially with respect to the actual type of work to be done. However, there is much evidence from this study to indicate that the post-discharge careers of most former psychiatric patients probably do not, as a group, differ drastically from that of a comparable non-patient group, although such a comparison was not possible. Certainly it augurs well for the mental patient's rehabilitation potential to know that most of the sample, whether married or single, were self-supporting.

A sure demonstration of the fact that rehabilitation begins and could be enhanced during the patient's hospital stay is seen in the finding that most of them found social activities, ward duties, occupational and physical therapy, patient government and so on helpful in their later adjustment.

Interestingly, having special vocational skills seemed to result in more rather than fewer job changes, which is interpreted not as training being an obstacle to job stability but rather as affording the person greater employment opportunities and freedom to change until congenial employment is found. Graduate college careers seem to guarantee the greatest degree of vocational stability, and four of every five with special training could return upon discharge to the job held at the time of hospitalization.

The problem of the use of job variability, or number of jobs held, in the post-hospital period as an index of "adjustment" or "successful rehabilitation" has received examination in the study. It is impossible, and a common error of some studies in this area, to render conclusive evaluations or judgments of the degree of "adjustment," no matter what the indexes being used, unless the study has been controlled with a matched "normal" sample. Only with such a control could a baseline for "normal" adjustment be established. However, certain possibilities suggest themselves regarding the extent of job change:

- A former patient taking his old job back, or holding on to a single post-discharge job, is not necessarily making a healthy adjustment, although it may be labeled as "stable." It could be an indication of fear of change, lack of self-confidence, or resignation to an occupation which may have originally precipitated the emotional disturbance. On the other hand, having several post-hospital jobs could also be based on a high degree of self-assurance (and therefore the psychological freedom to experiment), and a need on the part of more youthful men for a period of occupational trial-and-error (5). Most of those working

at the time of the study were satisfied with their current job.

- The individual who changes jobs in the post-hospital era may in fact be unsuccessfully treated or rehabilitated, so that he has not yet built up sufficient physical and psychological stamina to withstand the pressures of many occupations.

- The frequent job-changer may, on the other hand, feel dissatisfied or frustrated only in certain types of jobs, or he may feel realistically that he needs further training, education and counseling assistance to obtain more satisfying employment. A recent study by a Veterans Administration hospital (6) indicates that training, counseling and placement services for psychotic patients pay off with a high degree of job success and earning power.

- If in his treatment and counseling the ex-patient found that the emphasis was laid upon "the job" without much concern for the kind of job, and if the patient felt this would please the hospital staff, rehabilitation personnel and his own family and friends, he could have accepted the first or easiest job he found. Later this job might be ungratifying and he would have to look further afield.

- The fact of residence in a psychiatric hospital not only forces a period of unemployment upon the individual, but places him, because of community ignorance and prejudice, in a more vulnerable position than the non-hospitalized person. In any case, final judgment regarding a patient's rehabilitation success will have to rest on a consideration of multiple factors, rather than on a single factor, in the individual case.

Although it was evident that much employer and community bias against hiring psychotic patients still exists, these seemed to characterize a minority of cases. For the most part, wherever they were mentioned by the respondents, the employers seemed quite generally willing to hire, or rehire, the ex-patient. And family, friends and other community agencies seemed frequently willing to help the more dependent ones. Furthermore, the earning power of the former patient did not seem to suffer drastically after he returned to the community, and the fact that only a fifth of the sample were receiving some kind of therapy may indicate a high probability that the mental patient may achieve a large degree of successful and gratifying vocational rehabilitation, even when left to his own resources. However, major needs for effective vocational assistance were discovered, with the conclusion that suitable services would increase the probabilities for happier and more productive ex-patient citizens.

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HARRY ESTILL MOORE

Some emotional concomitants of disaster

In May 1953 a tornado swept through the northern section of San Angelo, a small city in the western part of Texas, causing 11 deaths, injuring more than 150, totally destroying 320 homes and causing major damage to 111 others. Damage was estimated to be well over $3,000,000. In June 1954 a second tornado approached the same area but did not strike. The previously devastated part of town, and additional territory, were deluged by a heavy rainfall, battered by winds up to 65 miles an hour and hail which broke many windows, pounded large holes in roofs, and beat vegetation into the earth. Damage was estimated at slightly less than $2,500,000. No one was killed and only two persons were injured; but lightning had struck twice in the same place—almost.

Following the first storm, research was done in the area by the writer and assistants from the department of sociology of the University of Texas.[1] The second catastrophe gave a unique opportunity to study the impact of disastrous weather conditions on a twice-exposed population. Research in the community was resumed with the aid of grants from the committee on disaster studies of the National Academy of Sciences-National Research Council

Mr. Moore is in the department of sociology at the University of Texas.

[1] The study of which this paper is a partial report was financed by grants from the National Academy of Sciences-National Research Council committee on disaster studies, and the Research Council, the Institute for Public Affairs and the Hogg Foundation for Mental Hygiene, all of the University of Texas. Academy-Research Council funds were derived from the federal Civil Defense Administration, the medical services of the Army, Navy and Air Force, and National Institute of Mental Health. The conclusions presented are solely those of the author and not necessarily those of any of the sponsoring agencies.

and the Hogg Foundation for Mental Hygiene.

A schedule was constructed on the basis of a partial analysis of the first research effort, and administered to 114 representatives of the 150 families in the storm pathway who had been interviewed previously. Fifteen items were duplicated in the two schedules, but the major emphasis was directed toward uncovering new material directly related to experiences in the two disaster situations.

In addition, 22 intensive interviews were obtained from persons reported to have suffered severe emotional concomitants of one or both of the storms. A few of these persons were members of families interviewed following the first tornado. In only one case was a second interview denied.

Comparison of the two samples on several objective, factual questions indicated no significant variations, although it perhaps should be noted that slightly higher percentages of the second sample reported home and automobile ownership. This well may have been a result of the first storm. Relief funds from the Red Cross and a local disaster fund had amounted to $266,000, of which about $220,000 went for rebuilding and refurnishing the homes of victims. Physically the devastated area was in better shape when the second storm hit than it had been at the time of the first. Partly owing to political considerations, the city administration had extended water and sewage service, improved streets and remitted taxes. Makeshift homes had been reconstructed more substantially. The effects which remained—and we were to discover many—were to be found primarily in the personalities of the residents and their relationships with others.

Storms are no strangers in the San Angelo area. The one psychiatrist in the city expressed the definite opinion that there is an endemic fear of weather among the residents, and he cited frequent anxious inquiries as to means of escape, in case of a storm, from his air-conditioned consultation room in which there are no windows. At the same time, he said, since these people have a strong feeling that it is unbecoming to admit fear or other emotional reactions only one patient came to him as a result of the tornado and none following the second storm. Pharmacists reported almost no noticeable increase in the sale of sedatives at either period. Welfare workers, with perhaps more intimate contact, also reported no observed incidence of serious emotional difficulties growing out of these experiences.

What had been thought of as the most reliable and productive sources of information produced results only negative to the hypothesis that disasters of the magnitude of these would cause prolonged emotional consequences. It was only when we went to the victims themselves, and to the school superintendent with his close contact with children, and through them with parents, that we began to accumulate evidence to support the hypothesis.

The school administrator reported a "high storm consciousness" among pupils and parents, evidenced by increased uneasiness and restlessness of pupils and by the fact that many parents came for or telephoned to request that their children be sent home on the occasions of one tornado warning and several dust storms which had darkened the skies during the year between the storms. During the same period, discipline problems had "practically disappeared," and a "Youth for Christ" movement gained great headway among the pupils. This movement had been present for some years, but it was not until after

the tornado that it had really prospered. During the year following that event, more than 200 of the 1,700 pupils had become active, and during the last week of May 1954 revival services were conducted by pupils each night in the school auditorium with an even larger number of pupils and adults participating. Where this activity had largely been ignored, or slightly deprecated, it came to be thought of as a source of status as well as security. Members of the high school football team began the custom of attending one church after another in a body.

Such a change in activity is not in itself acceptable evidence of emotional damage, of course. It could be, on the other hand, a healthy adjustment to an environment now seen as more dangerous. In either case, it indicates that these people had developed a more emotional behavior pattern.

Several cases of illness of seemingly emotional origin following one or both storms were reported in interviews. One woman said she developed a limp which persisted for some weeks, although her physician assured her there was no injury. Another reported blindness for several days following the storm. A third experienced temporary inability to recognize intimately known family members. One informant said that more than a year later she was unable to use an air-conditioning machine because of the sound of air being pulled through it by a fan; this same person said, however, that on a trip to Nevada neither air conditioners nor high winds had any effect on her. Several persons reported unexplained weakness, insomnia, nightmares, loss of appetite and general depression. Often, it was reported, these symptoms did not appear immediately following the storm; some did not appear until intense activity following the acute emergency had ceased. One family reported the complete recovery of a member from a chronic illness after he had been active in rebuilding the home. Such cases are suggestive, of course, of the therapeutic value of meaningful activity following a crisis situation.

Respondents to interview by schedule were asked if they felt that they had fully recovered from the first storm when the second struck. Only slightly more than one-fourth (28%) said they had. Of the total sample, almost one-third reported they still had emotional problems within their families and about one-fifth reported both emotional and financial problems; a small number listed emotional, physical health and financial difficulties. Thus, well over one-half these persons admitted to emotional problems more than a year after the experience. Thirteen percent mentioned only financial problems. Even so, the statistics on emotional concomitants showed great change when compared with results of the first interviews. At that time about three-fourths (73%) reported some family member suffering emotionally from the tornado.

More objectively, possession of storm cellars in the neighborhood had increased from 8% to 33% during the year between the storms, and many reported using them whenever the skies darkened. Of our sample, 30% used storm cellars during the second storm; 70% reported their tornado experience was actively in their consciousness as they met the second emergency. Their feelings and activities at the time were described in such terms as "very nervous and afraid," "completely helpless," "physically ill," "went to church" or "put the children to bed and tried to stay calm." One group of five fled in the family car. Almost 60% of the families with children

reported "much more" fear of unusual weather among these members as a direct result of the second storm.

An interesting, and pertinent, attitudinal affect is revealed by two questions regarding financial burdens growing out of the second storm. Sixty percent of our sample reported loss or damage of property. Average loss to homes of sample members was $545, with additional losses averaging $132. Yet, when asked later in the same interview whether the second storm would "place new burdens on the family," 68% answered negatively. Clearly this discrepancy could not result from misunderstanding; rather it seems certainly to refer to a feeling of self-reliance and ability to meet adversity without admitting hurt. Furthermore, in view of the much greater prevalence of emotional than financial problems, it is interesting that in answer to the "burden" question, financial problems were mentioned five times as often as were emotional ones by those confessing to have "burdens" at all. These answers would seem to fit in with the observation that persons in the community placed a high value on self-reliance. The interview materials give a strong impression of reluctance on the part of informants to admit anything more than "nervousness" or to seek medical aid for anything other than physical illness. Nonetheless, ample evidence of pervasive and prolonged emotional stress was given by these same respondents in reply to other questions and in free interview situations, and was adduced by such observers as the school superintendent. For example, 15% of the sample said they were planning actively to leave the neighborhood. Results from the first interviews indicate that less than 4% of the victims of the much more serious disaster reacted similarly. Hence the probability of a cumulative effect on their attitudes.

One means of escaping the dilemma in which these persons found themelves was to project their fears to others. Possible use of this device is indicated by the fact that 60% of the informants thought the second storm would have undesired emotional effects on the children of the area; 20% were undecided as to this effect. Negligently the adults were not asked to report on themselves. One mother asserted her young daughter was so affected that she frequently vomited, could not remain seated when the siren at a nearby fire station was sounded and showed other symptoms of emotional damage. But the daughter curled up on a couch and slept through the description of her difficulties while the mother became upset to the point of weeping. It was evident that conversation centered on her disaster experience did not have the same type of effect ascribed to the sounds of sirens.

Similarly, more than half the respondents said they had not and would not offer donations to victims of the storm, but about two-thirds felt that the Red Cross or some other public agency should do so. Here we are dealing with a fundamental value—the obligation to aid one's neighbor in time of difficulty—with the probability that more persons said they would make donations than actually would have. But it must be recalled that more than 70% of these persons had received aid from some agency following the tornado and that disaster relief is one of the strongest arguments used in soliciting funds for the Red Cross and the Salvation Army, thereby furnishing ready-made rationalization for persons unable or not desirous of coming to the aid of neighbors.

Events of the magnitude of these storms demand some sort of explanation. A series of questions were asked in an effort to get at the conceptualization of the disaster by

those who had experienced it. In reply to the question "Why do you think this storm hit Lake View?" slightly more than half those questioned offered an opinion. These "explanations" ranged in nature from religious ("God's will" or "punishment") to quasi-scientific ("storms follow the river valley and are deflected into this neighborhood by the dam across the river"). Between these two types is found a third type most often couched in reference to detonation of nuclear devices by the military. Of these by far the most frequently given was God's punishment idea, offered by 21% of all persons interviewed. Furthermore, when the question is made more general by asking why the informant thinks so many disastrous storms are hitting the United States, the percentage of those ascribing this situation to Jehovah rises to 31. Similarly, the percentage of those who ascribe disaster to explosion of nuclear devices rises from 5% to 18% of all those questioned.

The temptation is strong to hypothesize on the basis of these figures that as the disastrous event becomes more distant in time or space, it is more likely to be rationalized in terms of some vaguely conceived, but not demonstrated, cause. Since "will of God" and "science" are the two such categories in our culture which are most revered, and most awe-inspiring, it is not suprising that they should be invoked in this instance.

Further support for this hypothesis is found in replies to a question as to whether these persons knew of any protection against such disasters. Almost three-fourths said they did not. But 27% did believe it possible to secure protection, and almost exactly two-thirds of these offered prayer, leading better lives or other means of escaping God's wrath as efficacious. The remainder placed their faith in a good storm cellar or in a combination of storm cellar and prayer. No one suggested political action to curtail the military nuclear development program. This perhaps reflects the prevailing attitude as to the power of the person to influence these two sources of potential disaster.

If these persons felt little could be done to prevent disasters, they nevertheless had definite attitudes toward the agencies of relief and rehabilitation active following the event. In both interviews respondents were asked to express an opinion of the nine agencies offering relief and other services, and these agencies were then ranked in order of preference. Revealed attitudes were consistent in 62% of the cases. Most of the changes recorded were toward a more favorable attitude; only 3% of the opinions were more negative.

In these rankings, it is notable that local churches moved up on the second interview from third to first place and that the local disaster fund moved down from fifth to seventh position, pointing again to the emotional nature of the evaluation. Military forces active in the situation were near the top in both rankings, while the Red Cross and the federal government were eighth and ninth respectively, in both. Impersonality and bureaucratic procedures are characteristic of these two agencies, and this is offered as a possible explanation of their rankings.

Respondents were asked in both interviews to express their opinions as to whether their neighborhood and city would be better off, about the same, or worse off after the storms. This was done in an effort to get at the fundamental emotional tone induced by these catastrophes. Again changes in expressed attitudes were tabulated in terms of change to more favorable or more negative. While 52% of the responses remained unchanged, 13% became more favorable in their outlook on the

future; 2% switched from a "better" to a "worse" forecast of their future.

Undoubtedly the efforts of city officials to improve the stricken area are reflected in the optimistic tone of these replies. But results from the same question in Waco following the 1953 tornado in that town gave only slightly less optimistic replies. Furthermore, the knowledge of the residents of these communities that they had met a severe disaster, had survived and rebuilt their cities appears to have developed a feeling of collective confidence. In addition, the recognition which came to them in the form of donations and more direct help from their fellow citizens seems to be another factor of importance. Considerable hostility existed between Lake View and the remainder of San Angelo. But during an interview a woman asserted this had largely disappeared. "I can go down the street now and if I say I'm from Lake View, they are better to me and nicer than they used to be. And it took just that [tornado] to make it so."

In conclusion, it appears evident that the emotional concomitants of these two disasters were more severe and more lasting than the economic consequences, severe though the latter were.

But loss was thought of primarily in economic terms by these persons and there was reluctance to recognize or to make manifest this emotional stress. However, it was not difficult either through schedules or through more intensive interviews to demonstrate the widespread existence of the emotional reactions described. This tendency to think of loss in economic terms may explain why so little attention has been paid to the more lasting emotional effect of disaster by students of such phenomena. By the same token, it indicates the need for research in this area by persons skilled in recognizing and delineating such difficulties when they are not clearly recognized by many of those suffering from them.

HELEN L. BECK

Short-term case work service in a preadmission-admission unit of a mental hospital

Short-term treatment in case work is always geared to the increase of effective ego functioning in a specific area. It has been a technique used for years in emergency situations in such agencies as the Red Cross or Travelers Aid. Increased attention is being given to such an approach in other settings at the present time.

Experience shows that even in agencies set up for long-term case work contact a large percentage of cases do not continue beyond 3 interviews (74%). National statistics on family agencies indicate that 53% of the cases accepted for service had fewer than 2 interviews (10% no interview, 43% one interview), 29% had between 2 and 6 interviews and only 12% had 7 or more interviews. Although statistically every case that had more than one interview is counted as a continued service, a case that has fewer than 4 interviews is by its nature a short-term service. Whether these cases were set up from the beginning to be completed in this short period of time, or whether the client withdrew from contact would have to be determined. However, the decision regarding length and intensity of contact should not be left to accident, but should be based on diagnostic criteria.

As a rule, a client in an acute crisis is looking for some immediate relief of pressures. The emergency situation may have been brought about by conditions outside the control of the individual or caused by long-standing mismanagement of the situation by the client. The fact remains that the usual patterns of behavior are of no help

At the time she wrote this paper Miss Beck was with the Cleveland Receiving Hospital and Ohio Institute of Psychiatry. She is now the chief psychiatric social worker in a new unit for mentally retarded children at St. Christopher's Hospital for Children in Philadelphia. The unit is sponsored by the U. S. Children's Bureau.

in the handling of the emergency. Case work treatment, to be effective, has to be focused on treatment of this immediate emergency. The service may end after the crisis has been handled or continue after the immediate pressures have been relieved, according to the needs and inclination of the client. He may lack readiness to involve himself in a long-term treatment situation, either because of his personality make-up, his comfort with his usual life situation, or the severity of the crisis he is currently facing.

Apart from these diagnostic considerations, choice of short-term treatment may be prompted by agency setting and purpose. This has become increasingly apparent in settings where case workers function as members of a team. Case work goals in such a setting have to dovetail with the over-all goals of the team. Adaptations to the case work approach have to be made in the interest of the over-all agency functions. In a hospital, for instance, a patient may be medically ready for discharge before he is emotionally prepared to return to the community or before his social problems have been sufficiently worked through. To achieve maximum gains for the client in such a situation, worker and client have to select priority areas for case work help. The worker needs to develop insight and skills that will enable him to give effective help in short-term contacts. Such skills would be:

1. Clear understanding of his own function and the limitations within which he has to operate, so that he can select treatment goals attainable with these limits.[1]

2. Ability to break down a seemingly overwhelming situation into its elements and then help with the handling of the most pressing aspects of the problem, one at a time. This will make apparently insurmountable difficulties amenable to solution.

3. Ability to focus diagnostically quickly and to develop a feasible plan promptly.[2]

4. Ability to use available time economically.

5. Ability to go out quite directly toward the client without overwhelming him. The worker needs to involve himself in the situation and still leave the client free to make his own decisions and necessary transfer.

6. Ability to use authority based on professional skill and knowledge rather than on legal considerations.

Over the last year and a half we have experimented with the development of specific skills in short-term treatment, in the preadmission-admission service of the Cleveland Receiving Hospital and State Institute of Psychiatry. Although our findings are by no means conclusive, they may be of interest to workers in similar settings and may be applicable to other settings as well.

THE ADMISSIONS SERVICE

Social services are, as a rule, not involved in the admissions to a hospital. Whether a patient should or should not enter a hospital is obviously a medical decision. However, the families and patients affected by such a decision have many problems, related to the medical difficulties, with which they need case work services. They need to understand the implication of the illness and of hospitalization, and their choices in available plans. Misconceptions regarding

[1] Eileen Blackey, "Social Work in the Hospital," *Social Work* 1(April, 1956), 43.

[2] Leontine Young, "Diagnosis as a Creative Process," *Social Case Work*, 37(6, 1956), 275.

hospital care and anxieties around these may have to be cleared up before plans can be accepted by them. Help with practical arrangements may be necessary.

These needs of the patient and the people involved in his hospitalization are increased when hospitalization is necessitated by mental illness. Social as well as psychiatric factors have a bearing on whether a patient should enter a mental hospital, whether he should be referred for out-patient psychiatric care or for some other kind of help. The doctor can make his disposition best if he has knowledge of both psychiatric and social factors available for a decision.

The preadmission-admission unit was set up as part of social service to provide for these needs outlined above.

THE SETTING

The Cleveland Receiving Hospital and State Institute of Psychiatry is a state mental hospital set up for the treatment of acute, short-term mental illnesses. It functions in three areas: treatment, training and research. The social service department of the hospital consists of 5 trained group workers and 12 trained case workers. Eight of these case workers serve hospitalized patients and their families during and after hospitalization. Four case workers provide services in the preadmission-admission unit. A case aide has been added recently to this unit on an experimental basis.

The preadmission-admission unit carries between 170 and 200 cases a month, with interview volume between 400 and 600. This includes personal as well as telephone interviews. The telephone contact in the unit has to be considered as an interview, since frequently a complete and complicated case work service is given over the telephone. Almost half of the cases coming to the attention of the unit do not need hospitalization but referral to other facilities. This underlines the importance of such a service.

The aims of the unit are:

1. To help people who apply to the hospital by determining what their needs are.
2. To facilitate admissions by other than court commitment.[3]
3. To attempt to involve patients and families as much as possible in decisions regarding plans.
4. To assist patients and families in using the hospitalization period positively by preparing them carefully for this experience.

Because of the nature of the unit, service is always geared to referral elsewhere, either to an agency outside the hospital or to the in-hospital worker. Service is also always brief, although there is considerable variation in the length of the contact. A case may be active from a few hours in an emergency situation to several weeks in situations where problems have to be clarified and resistances worked through. The number of contacts and their intensity also vary and are not in direct ratio to the length of the contact.

SKILLS IN SHORT-TERM TREATMENT

Work in the unit is focused mainly on the following areas:

1. Establishment of a relationship that will enable the client to move ahead with plans and permit transfer to another worker after admission or referral to another agency. This is in contrast to the relationship in a long-term treatment situ-

[3] Ohio has a law that permits mental patients to enter a State Hospital voluntarily or by certification without loss of legal status.

ation which is developed in terms of long-range goals. The emotionally seriously handicapped client is often unable to establish a treatment relationship that could be sustained over long periods and through the stresses of deep-level therapy. He may be quite capable of developing a relationship that will enable him to use a worker in one clearly focused trouble area.

2. Gathering of diagnostic material that will aid the worker in developing the best possible plan for the patient and his family; that will aid the doctor in his disposition of the case; and that will provide the basis for further case work contacts with the in-hospital worker. Again, such diagnostic material is used differently in a short-term contact from the way it is used in long-term service. The worker will generally be guided in his handling of a case by the psycho-social implications of the material. As a rule he will abstain from using it directly with the client. It may not be indicated in the total situation. There may not be time to handle the feelings aroused by the direct use of diagnostic material that may hamper action necessary for a solution of the current emergency.

3. Establishment of collateral contacts on a selective basis for clarification and amplification of facts related by the client and as a protection against working at cross-purposes with other agencies active in the situation. In short-term service particular attention has to be given to maintaining a proper balance between working with the patient and his family and the use of outside assistance to speed plans and increase the efficiency of plans with other workers.

4. Assessment of strength and weaknesses in the situation.

5. Development of a feasible plan.

6. Assistance to the persons concerned with the carrying through of these plans.

These seem many steps to be taken in a short contact. We have found they can be taken in a surprisingly short time if necessary. The ability to recognize quickly the most important points in a situation, to see them clearly and to focus them for the clients will help in following through these steps. Time needs to be used economically in the areas where it has most effect.

The following are case examples selected to illustrate the steps taken. Most of the situations described will actually illustrate a number of steps, although they were chosen particularly to point up one or another.

Since the study is focused on case work treatment, the role of the psychiatrist in the steps taken is not discussed in any detail in the examples. Each case is cleared with the chiefs of services. There is variation regarding the timing of such clearance in relation to the material available and the needs of the case.

In each of the cases presented here, the psychiatrist was involved in the planning.

CASE I: RELATIONSHIP

Contact in this case lasted for about a week. The patient involved was potentially dangerous. However, the worker felt that forced hospitalization would be quite destructive to him and would interfere with hospital adjustment and later recovery. The doctor concurred in this thinking and in the plan that was developed. Certain safeguards were set up, a contact with a community agency was made and a neighbor stood by to support the patient and take action should this become necessary.

Mr. K, the patient, was referred to us in relation to his wife's hospitalization, and during the interview he began to discuss his concern over his own ideas of reference.

The social worker pointed out to him that he too needed help. The hospital psychiatrist who saw him at the request of the social worker advised him that he should remain in the hospital. Although he agreed to this, he felt that there were "things he had to attend to" before he could enter the hospital. The worker was well aware of his limited ability to form a relationship and of the tenuous quality of such a relationship. She knew that if she were to help Mr. K at all she had to move at his pace to develop a relationship that would help him trust her and use her to help him with plans. She also knew that such a relationship could act as a deterrent against sudden complete disintegration. The worker therefore gave recognition to the seriousness of the situation without trying to alarm Mr. K. Ego support was given by recognizing his ability to plan and carry through plans, and his awareness of his own condition.

During the days that followed, Mr. K maintained a telephone contact with the worker. When the patient realized that his work ability had decreased, he came to the hospital for admission. Again he was unable to stay, although he signed the first admission papers. It seemed that he was beginning to anchor himself to the hospital. He promised to enter the hospital the next day. Some thought was given to detaining him against his will because of the potential danger. The doctor was again consulted. He felt that the risk could be taken in view of the relationship between the worker and the patient and the fact that the neighbor could be counted on to be supportive, and move quickly if necessary.

Mr. K came the next day. He was calm, signed the rest of the papers and went to the ward with a feeling of relief and achievement. The sense of achievement, at the time of threatening ego breakdown, can be very strengthening and go a long way toward healing.

CASE II: GATHERING OF DIAGNOSTIC MATERIAL

The following case illustrates how difficult it is for relatives to give an accurate, realistic picture of a situation while under the pressure of an acute emergency, and how often they omit the most pertinent details.

Mrs. S applied for hospitalization for her young son. Dick was seriously mentally retarded, but his father had always been able to manage him by keeping the boy close to him and finding simple work for him in the family's business. After the sudden death of the father, Dick was abruptly left without this support and guidance. The impression from the mother's description of the situation was that she could not handle him and that he needed care in an institution for the mentally deficient. However, since the family had a physician who had cared for the boy for a long time, the worker thought it safer to get permission to contact the physician.

In discussion with the doctor it was found that Dick, after the father's death, had become despondent and had developed a number of clearly psychotic symptoms. While eventually he would have to be institutionalized for his mental deficiency, he did need immediate psychiatric care. The mother, although aware of the psychotic symptoms of the son, was able to describe them only after the worker knew about them, and could help her discuss them.

CASE III: ESTABLISHMENT OF COLLATERAL CONTACTS

This case was selected because it shows clearly how treatment begins with the first

contact. A case work technique aimed at setting up the case is already part of case work treatment. The use of collaterals sets the stage for the later contacts. The client gets a first inkling of the worker's capacity to control the client's acting out, which is helpful and therefore reassuring to the client.

Jane came to the hospital at the suggestion of a private psychiatrist. She complained of utter loneliness and despondency. She felt completely rejected by her family. She assured the worker that her parents would not be interested in any plans she was making and that they need not be involved in her hospitalization. Jane had been known to an excellent community agency. Permission was asked for and granted to contact the agency. The agency worker was inclined to agree with Jane's description of her parents, whom she knew only slightly. However, our admission case worker had become suspicious of Jane's manipulativeness as apparent in the intake interview and as described in the report of the other agency. She thought it wise to get a first-hand impression of the parents. This seemed particularly important in view of the girl's youth and the seriousness of the step she was preparing to take. Furthermore, she would need her parents on discharge. It also seemed important to clarify hospital authority and need for an orderly procedure. The worker insisted that she be permitted to try to contact the parents.

The parents responded quickly and warmly to the fact that they were considered of importance to their daughter. It became obvious that the patient had always taunted them by keeping them away from her affairs and then accusing them of lack of interest. Contact with the parents not only provided a more accurate picture of their interest in their daughter, but also provided information which the patient had withheld. The worker learned that the girl, in her desperate disorganized search for help, was currently in therapy with still another psychiatrist who was unaware of hospital plans. Permission was obtained to contact this psychiatrist too, and to get the latter's participation in whatever plans could be developed cooperatively.

Case work process was focused on curtailing the patient's acting out and manipulation. The patient was helped to see that she would have little return from her efforts to obtain help by continuing present patterns. However, no effort was made to handle any of this on a deeper level.

CASE IV: ASSESSMENT OF STRENGTH AND WEAKNESSES

The following case was completed in two short telephone contacts. The client, on phoning in, was obviously in a momentary panic and felt she needed to "do something" without being able to determine what she needed. It was not possible to get a complete history of her difficulties, nor did this seem necessary.

Mrs. T had been unable to sleep or eat since the recent death of a somewhat distant relative. Friends were telling her that she would be "losing her mind" if she continued this way. It seemed that Mrs. T did not really want hospitalization, although the protection hospitalization would afford from the stresses of daily living seemed enticing to her.

To get to the crux of the present upset, the worker focused away from the immediate panic. In discussion, Mrs. T sounded upset but rational and well organized in her thinking and daily functioning. She maintained her household and a job with-

out difficulties, continued relationships with family and friends and pursued outside activities. When the worker wondered whether there was not something more immediate than the death of a distant relative that was upsetting to her, Mrs. T spoke about a serious marital problem of long standing. Mrs. T showed little response when referral to a family agency was suggested as an alternative to hospitalization. However, she became quite interested in the possibility of psychiatric out-patient care.

The client's strength here lay in her ability to continue to function in spite of a serious stress situation, and in her capacity for evaluating alternate plans offered. The extent of the weakness in the situation (the marital difficulties) was not known. The client's preference for psychiatric care over family service help may indicate what it might be. Quick plans for hospital care could lead to serious breakdown of defenses in a situation like this, rather than help with the ego functioning.

CASE V: DEVELOPMENT OF A FEASIBLE PLAN

Acceptance by the hospital is not enough to get a patient to come into the hospital. Even when hospitalization is the answer to a patient's problem ambivalent feelings about this on the part of all persons involved have to be anticipated and dealt with. Because of their guilt feelings the family suddenly may wish not to be involved in the actual hospitalization procedures. Rejection of the patient or resistance to the plan by one member of the family may have to be worked through. Considering again the time element, particularly in an emergency situation, the handling requires full understanding, compassion and very quick thinking on the part of the worker. The possibility of physical danger to the people involved also has to be considered.

The following case is an illustration of development of the plan, and help given step by step toward its acceptance:

Mr. N had been mentally ill for a number of years and was aware of this. He had had one private hospitalization, but had left the hospital because of his fear of treatment. He was potentially dangerous, and this was one area of his illness of which he was unaware. His wife had delayed taking steps toward hospitalization out of fear of what he might do. Finally hospitalization was agreed upon.

The morning Mr. N was to enter the hospital he stipulated that he would come only if binding promises regarding treatment were made. Both he and his wife knew that such a promise could not reasonably be expected. Efforts by the worker to talk to him by phone and appeal to his reasonableness, which outside his paranoid system was good, had little results at first. He became upset, although he remained friendly. Plans for Mrs. N to call outside help seemed not possible at that moment. Mrs. N was encouraged to try to bring her husband for at least a personal discussion of the matter and to keep in touch with the hospital. An hour later the couple walked in. Mr. N half jokingly repeated his terms, but responded to the worker's statement that he knew he was not reasonable and that he would resent efforts to fool him. Talks with the worker and the doctor had a calming effect. He responded to efforts to help him maintain controls. He obviously also began to feel easier about a place where a sincere effort was made to understand his feelings and to help him with them. When it became apparent that he would be unable to make a decision, the

decision as to whether he should be retained against his will was left to Mrs. N. When she decided for this, Mr. N was informed that the doctor felt he needed to stay. He made one effort to walk away, but desisted when he realized that he could be detained by the attendants. He was encourged to maintain his self-control and not put himself in an undignified situation. His request that his wife accompany him to the ward was granted. He settled quickly into hospital routines and remained amenable.

This process had taken about one hour. It saved hospital time in the long run. Had he been physically overwhelmed, the feelings aroused would have rankled for a long time against his wife and against the hospital. Valuable treatment time might have been lost. Even after a patient has become accustomed to the hospital, a flare-up of angry feelings is quite likely at the time of discharge if there is residual resentment.

CASE VI: ASSISTANCE WITH PLANS

There is no clear delineation between one and the other technique and as mentioned earlier each illustration given shows a number of steps involved. The cases were chosen for the area of emphasis. In the following case illustration, emphasis was on helping the client with a plan that was basically not his, but seemed sounder than the plan developed partially in self-defense by the patient's father. The hospital knew that Mr. R's anxiety was somewhat exaggerated. However, since he had a severe physical disability, his anxiety was a serious factor to be considered in any plan. Mr. R asked that his daughter be re-accepted for hospital care because of recurrence of previous symptoms. He wanted to tell her that she was to come for a routine follow-up visit. The worker discussed with him the possible repercussions of such a scheme and suggested a number of alternatives. It was decided that he would have some relative present when approaching his daughter with the need for re-hospitalization. He could then tell her that to relieve her present discomfort, the doctor had wanted to give some medication that had to be given in the hospital. He could also tell her that she would have an opportunity to raise questions regarding this plan on coming to the hospital.

Apparently this worked much more easily than the father had anticipated. On coming, Miss R asked for a "private" interview with the worker and with the doctor. She became intrigued when she found that she would be able to sign her own admission application and treatment permit. This possibility for some self-determination in a situation that had initially seemed completely beyond her control had a good deal of meaning to her. There was then no feeling about having been "tricked," no need for anger or guilt about this.

CONCLUSIONS

The techniques described here are not really different from techniques employed in any situation in which case work is effective. The differential lies in the application of these techniques and in the areas in which emphasis is put.

In short-term contacts these points are important:

Relationship. Service is often given in situations where no decision has yet been made as to whether the people involved in the contact will actually become clients. The type of relationship developed has to enable the client to accept service from the worker, as well as to accept transfer to another worker, either within the hospital or at another agency.

Diagnosis. There is need for great clarity

on the part of the worker regarding the psycho-social diagnosis and the possible solutions. He has to use time most economically, and reach out toward the client more actively than is usual in the more conventional situations. A complicated service may have to be given within a single contact that may not even be a personal one, but be conducted over the telephone.

The collection of collateral material has to be on a very selective basis to be available immediately for diagnosis and treatment plan without interfering with action by profusion of detail.

The use of diagnostic material has to be carefully weighed in relation to the immediate situation.

Treatment. The worker has to align himself with the healthy part of the ego. The techniques used are mainly clarification and support. The worker must have faith in the capacity of the client to use such an approach.

ALAN O. ROSS, Ph.D.

Confidentiality in child guidance treatment

The confidentiality of psychotherapeutic interviews is a well-established and generally accepted principle. Inherited from medicine on its ethical basis, practical considerations have made it a virtual *sine qua non* in psychiatry. Without the assurance that his communications will be held in the strictest confidence, no patient would feel free to divulge the highly personal material which needs to be verbalized if treatment is to be effective. In the psychotherapy of adults the therapist will usually assure his patient during the first interview of the confidential nature of treatment. In the rare case where it may appear therapeutically necessary to diverge from this principle, the conscientious therapist will attempt to obtain the patient's specific concurrence before revealing material obtained during treatment to an outsider. This rare instance where confidentiality thus becomes relative instead of remaining absolute is usually one involving an acute danger to the life of the patient or of others.

The concept of absolute confidentiality also becomes slightly modified when treatment takes place not in individual practice but in a clinic or training setting where the need to discuss case material with supervisors or other members of the clinic staff brings third parties indirectly into the therapist-patient relationship. In a clinic, these third parties also include clerical personnel responsible for record-keeping and the confidential relationship thus obtains between the patient and "the Clinic" as a professional institution. The primary ethical responsibility for confidentiality

Dr. Ross is chief psychologist at the Clifford W. Beers Guidance Clinic in New Haven, Conn.

rests at all times with the therapist. Whenever treatment takes place under these circumstances, the patient should be made aware that the principle of confidentiality is being extended to include other, indirectly involved individuals.

The practical need for assuring the patient of the confidentiality of his communications, important in the treatment of adults, becomes crucial in the treatment of children. Most children, and particularly those being treated for emotional disturbances, have had important experiences which they entrusted to or shared with one adult, who promptly revealed the information to another, to the embarrassment and chagrin of the child. A neighbor, observing the child in some "forbidden" activity and rushing to tell his mother; mother telling father of the child's misdeeds; or parents sharing a laugh over something "funny" the child said or did, are frequent childhood experiences. Often, too, a child may have worked up courage to make known to his mother an important question or a confidential experience, only to have the mother share the material with the father or another adult in the most casual manner. From such situations many children generalize that adults cannot be trusted and when a therapist first enters the picture he is usually viewed as just another adult, in alliance against the child.

The initial experience in a child guidance clinic contact tends to reinforce this idea, which is compounded by generalizations stemming from visits to the pediatrician or family physician. The parents usually contact the clinic before bringing in the child, who then comes to a place which is strange to him but familiar to his parent. In most instances the parents are unable to prepare the child adequately for his visit to the clinic, for no matter how well preparation was rehearsed with the parents during the initial contact it frequently becomes distorted or omitted entirely because of the parents' own anxiety and conflict about the visit.

The child, arriving at the clinic anxious and confused, has nothing but his own generalizations about doctors and adults by which to order this new experience conceptually. Being responsible for bringing the child to the clinic and having obvious familiarity with the physical layout and the receptionist, the mother is viewed by the child as having "the inside track" in the clinic—apparently being in conspiracy with all the other adults inhabiting the place. Assuming that the child is first undergoing an evaluation, as is usual at most clinics, he will at this point be seen by an adult who will either want to "play and talk" with him or give him psychological tests. It is unlikely that this contact will do much to change the attitude with which the child came to the clinic. He will undoubtedly assume (and usually correctly) that the "doctor" talked to his mother before he saw the child, thus getting her side of the story, and that he is going to talk to her again afterwards to tell her what he "found out" about the child. Everything that happens would appear to be for the mother and against the child.

As stated earlier, confidentiality cannot be aboslute in a child guidance clinic because information received from the patient must be shared with other staff members. The team approach in which mother and child are treated by different individuals requires that the two therapists involved in a given case frequently and regularly exchange information relevant to that particular family. This exchange of information may be oral

or written (through the medium of the case record) and it may take place in an informal discussion between the two therapists or in the setting of a staff conference, where the information is shared with yet other professional persons. This is a modification of absolute confidentiality, discussed earlier, and the patient is entitled to know that this condition obtains and that it is in the best interest of treatment progress. The adult members of a family in treatment will usually accept this relatively easily, and if any doubts about the confidential nature of communications should later on disrupt the treatment relationship, they can be worked through like any other resistance mechanism.

In the case of the child, however, the situation is somewhat complicated, for he may be expected to find it more difficult to conceptualize the nature of the therapeutic team operation. If, following evaluation, the child is taken into treatment, the therapist will have to establish a relationship of confidence and trust within which treatment can become possible. This task is complicated by the child's attitude of not trusting adults in general and the people at the clinic in particular. Again, as at the time of the first contact, the child is brought to the clinic by the mother, and although she is not in the same room, her physical presence in the building continues to make the child suspect that she will find out anything he may do or say. The question of confidentiality of the relationship thus becomes of paramount importance. The therapist will want to explore the child's feelings and thoughts about his coming to the clinic during the first treatment sessions. He will want to discuss what sort of a place the clinic is, what will and what will not happen to the child, and what he can and cannot do. As part of this general introduction to treatment the question of confidentiality should be taken up, but what and how should the child be told about it?

A statement, such as "Everything you do and say in your hour with me is strictly between the two of us and I won't tell your mother about it," is obviously incomplete but anything more than this raises a great many problems. If one adds "While you are playing and talking with me, your mother will be talking to her social worker and the social worker and I will be talking with each other from time to time so that we can all help you better," one tends to lend support to the child's initial suspicion that his mother will hear about what he says and does in his treatment session. It would thus be necessary to add a specific assurance that neither the therapist nor the mother's worker will tell the mother anything about what goes on in the child's hours. Unfortunately, even this extended statement fails to cover every potential situation. What if the therapist becomes convinced that a child is serious about a threat to commit suicide or that a 5-year-old actually plans to run away from home? Most therapists would feel obliged to inform the mother or another responsible adult so that this potential danger can be averted. At the same time, they would probably inform the child of their intention of doing so, trying to obtain the child's agreement but taking the required step with or without his concurrence. Does this mean that one should refer to such a contingency at the time confidentiality is taken up at the beginning of the child's treatment? One might say that one won't inform the mother of anything the child does or says unless one had first talked to the child about one's intentions. This is an innocuous enough statement for most adults, but a child with

limited abstract ability and only a vague concept of the future might easily find this confusing. He may well attend solely to that part of the statement referring to telling the mother, using it to confirm his suspicion and disregarding the qualifying clause altogether. It would thus seem best to keep the statement in its simplest form at the beginning of treatment, adding modifications at a later time when a relationship has been established and any resulting confusion can be more readily resolved.

The problem of assuring the child of the confidentiality of his therapeutic sessions seems complicated enough even in situations where therapists sincerely have no intention of communicating the child's material to the mother except in the most crucial situations involving the child's safety. While most therapists subscribe to this concept of confidentiality some advocate a further modification which might be called "limited confidentiality." Faced with the apparent lack of progress and productivity in the child's sessions and stymied in their indirect attempts to focus on an area in which they know the child to be holding back, they are sometimes inclined to introduce material obtained from the mother's hours directly in order to elicit movement on the part of the child. At the same time they will usually insist that nothing the child produces shall be transmitted to the mother. The principle involved has sometimes been referred to as "one-way communication" and introduces a critical complication. Limited confidentiality requires that one announce to the mother at the beginning of treatment that some of the material she brings to her worker will be used by the child's therapist in his treatment of the child. Since the time element does not make it feasible to obtain the mother's consent each time some of her material is to be used in this manner, the decision as to what is and what is not to be treated confidentially must, of necessity, be left to the child therapist's discretion and thus becomes arbitrary. If this were not so, at least two weeks would pass under a conventional once-a-week treatment schedule before the child's therapist could utilize a specific piece of information.

An example will help to clarify this: In a given week the mother tells her worker that the child has begun to refuse to go to school. In conference following this session, the child's therapist learns of this and decides that he would like to use this fact with the child, who has failed to mention it himself. The worker would now have to clear this with the mother in the subsequent week and to transmit the mother's reply to the therapist, who then raises the issue with the child in the third week.

The first problem arising out of an acceptance of limited confidentiality as a working principle has to do with the mother's reaction. Even though she may accept the rationale that this approach is therapeutically advantageous, the realization that some of the things she reveals to her worker are going to find their way to the child in some form or other may well result in her being less than frank in her treatment session. Not only may she fear that the child, in turn, might wish to talk about a topic with her before she is ready to accept such discussion without embarrassment or uneasiness, but she may also fear that the child might reveal to outsiders or the father something she does not wish to become known. Because of these concerns, many mothers will shy away from revealing sensitive material unless they are

fully convinced that the information will remain, if not with the worker, then at least among the professional clinic staff.

The second, and it would seem more serious, complication arises out of the child's awareness that he can find out some of the things his mother talks about in her sessions. This makes it very difficult to convince a disturbed child that communication of this nature really goes in only one direction. If he can find out things his mother says to her worker, how can he be sure that his mother will not also find out things he tells his therapist? A complicated statement, such as "Your mother will not find out what you say or do in your hours, but sometimes, when I think it will help you, I will introduce in your hours with me things your mother tells her social worker," cannot possibly be very convincing, no matter how simplified the wording. The realization that therapy material is carried back and forth plays into and tends to confirm the child's suspicion that the therapist cannot be trusted, and may well represent a major obstacle to treatment progress. It is highly probable that the apparent advantage gained by using the mother's material in the child's hours is vitiated by the reinforcement this lends to both the mother's and the child's resistances. For this reason it would seem advisable to carry out treatment in a setting where only information the child himself feels free to introduce is used in his treatment sessions.

A different aspect of the problem of confidentiality is that involving direct contact between the child's therapist and the mother. In the individual practice of psychotherapy it is generally accepted usage that the therapist either occasionally or regularly interviews one of the child's parents. The fact that treatment can be carried out under these circumstances would seem to demonstrate that this approach does not make treatment impossible, but one of the reasons the child guidance team approach was evolved is that such contact makes treatment more difficult because it interferes with the therapist-child relationship in many cases. That this is being recognized by therapists in individual practice is demonstrated by the recent trend of having social workers, charged with the responsibility of maintaining contact with parents, collaborate with private practitioners. In spite of the obvious advantages the team approach lends in the separation of treatment functions and the concomitant greater ease with which the child can be convinced of the trustworthiness of his therapist, there exists an occasional urge on the part of some child therapists to short-circuit the team and talk directly with the mother. When this urge becomes translated into action, it demonstrates a lack of confidence in the team partner who is thus shunted aside and a failure to appreciate and accept the principle of the team approach. In addition, it tends to disrupt the social worker's treatment of the mother; but worse than this, it jeopardizes the relationship between therapist and child. Knowing, as he ought to, that his therapist talks to his mother, the child cannot but assume that he is the topic of discussion and to fear that his therapist will not only divulge information obtained from him but also hear the mother's version of his behavior outside the clinic. Avoiding the treatment disrupting reaction which must follow this reasoning on the part of the child seems well worth relying on the social worker for interpreting to, and gathering relevant information from, the mother.

The therapist's urge for direct communication with the mother has its counterpart

in the mother's desire to talk directly to the child's therapist. It was pointed out earlier that the child comes to the clinic with certain preconceptions carried over from his experience with pediatricians and other physicians. It must be remembered that the mother, too, tries to order the new and threatening experience of coming to a child guidance clinic in terms of something she is familiar with, and thus tends to generalize from taking the child to a pediatrician to taking him to a "psychiatric doctor." In all the old situations she has known the physician examined the child, nearly always in her presence, and then told her of his findings and recommendations. In a child guidance clinic, however, she is suddenly excluded from the "examination" and has the recommendations interpreted to her by someone who has never talked to the child. Many mothers will react to this exclusion with resentment and a negative attitude toward the interpretations of the clinic's findings. If the recommendations are unwelcome and threatening, as statements of the child's disturbance and need for treatment invariably are, the mother may well refuse to accept them and fail to follow through on any treatment plan offered.

To avoid this reaction, many clinics are making it a practice to have the person who saw the child during diagnostic study join the mother's worker in interpreting the results of an evaluation. This not only places the weight of the doctor's prestige behind the statements made but it also enables the mother to ask specific questions of the person who has first-hand familiarity with the child. While this practice has undoubted advantages, it should be remembered that if the individual who saw the child during study is assigned the case for therapy, this direct contact with the mother may place him at a handicap in establishing a treatment relationship. For the child must feel that the only reason the therapist talks with him again is to "find out more things" in order to communicate them to the mother. The advantages gained from direct interpretation to the mother should always be weighed against the possible disadvantages such contact represents in the treatment situation.

Unfortunately, the disadvantages are not confined to the initial phase of treatment. Having once had direct contact with the child's therapist, the mother may expect that she can continue to talk to him directly. As pointed out earlier, any contact between the child's therapist and the mother during treatment is deleterious to the therapist's relationship with the child, but as treatment takes its slow and lengthy course many mothers will continue to want to know "what the doctor found out." This is why some mothers will try to buttonhole the therapist in the waiting room to ask him "how Johnny is doing." The mother's worker must be constantly aware of her patient's need to know what progress, if any, is being made with the child, so that she can interpret therapeutic principles to her and satisfy her legitimate desire to know what is going on. This means that the nature of treatment in general, and the practice of the team approach in particular, must be brought up again and again, and any attempt on the part of the mother to communicate directly with her child's therapist should be viewed not only as a failure to make this interpretation meaningful and acceptable but also as an indication of a weakness in the worker-patient relationship.

Unable to learn from the child's therapist "what he found out," and not satisfied with the worker's generalized statements about treatment progress, some mothers will attempt to elicit from the child in-

formation about the content of his hours with his therapist. This "pumping" frequently occurs soon after the hour, usually on the way home from the clinic and takes the form of such questions as "What did you and your doctor talk about today?" or "What did you do today?" While these queries would seem to reflect only casual interest (parents often ask their children what they did in school that day), they have a deeper meaning and can seriously hamper treatment progress. Such inquiries may indicate that the mother cannot permit the child to be close to anyone but her, so that her questions are attempts to insinuate herself into the child-therapist relationship. Again, "pumping" may reflect the mother's concern that the child will "tell on her," will reveal aspects of her life or of her relationship to the child about which she feels guilty. By asking him questions, she may unconsciously be trying to sabotage the child's treatment and this is exactly the result that these questions tend to bring about. Knowing that after each hour he may have to "report" to the mother on what he did or said, the child will soon censor his productions, the effect being the same as if the treatment hour were conducted with the mother present in the room.

Whenever either the child's or the mother's therapist discovers that the mother tries to "pump" the child in this manner, it will have to be taken up with the mother in order to try and have her desist. It may, in fact, be desirable to cover this point with all parents in one of the first treatment hours, possibly at the time the topic of confidentiality of interview content is dealt with, since many parents find it difficult to understand that the child is entitled to the privacy of his treatment hours and even more difficult to accept their exclusion from the therapist-child relationship.

Child guidance treatment is a costly procedure because of the duplication of professional services, nearly every case involving at least two staff members. This expenditure of money and time has proved worth while because it provides both parent and child with his own therapist, thus avoiding the treatment-retarding complications which often result when both members of a family are treated by the same person. Therapists in individual practice, who have to work with both parent and child, have to deal with these complications during treatment, thus spending valuable time on a problem which therapy itself creates and which the team approach is ideally suited to avoid. From the point of view here represented, this major advantage of the team approach over individual practice is vitiated when contacts between child therapist and parent are permitted or when the principle of limited confidentiality is accepted.

It would therefore seem generally best to forego the questionable benefits of limited confidentiality, operating instead within a framework where nothing either parent or child reveals in his hours is directly introduced into the other's treatment, and where contact between the child's therapist and the parent is held to an absolute minimum. In this manner optimal use can be made of the unique opportunities the child guidance team approach presents for the treatment of emotional disturbances of children.

ÖRNULV ÖDEGÅRD

A clinical study of delayed admissions to a mental hospital

The emphasis upon early hospital admission is old in psychiatry. When mental hospitals came into existence in the first part of the nineteenth century, making it possible to bring these patients under medical care, optimism soared high, and it was commonly stated that good results were certain if the patients were admitted during the initial stages of the illness. Statistics in proof of this were published (in Norway by Sandberg for the Gaustad Hospital erected 1855), and the reservations were commonly neglected. But gradually chronic cases accumulated, the initial optimism declined, and the mental hospitals entered upon a period of therapeutic nihilism when less was said about the importance of early admission than about the evils of overcrowding. Off and on there were signs of greater activity—for instance, in connection with the revival of occupational therapy—but a real wave of renewed optimism did not occur until after the introduction of the shock therapies around 1935. Again statistics appeared that showed the importance of early admission. The medical profession as well as the general public responded fairly well, so that the average duration of illness previous to admisison decreased markedly (Table I). Nevertheless, the number of delayed admissions is still considerable, and it is generally felt that they represent a serious social problem as well as a loss of therapeutic possibilities.

For the purpose of the present study

Dr. Ödegård is professor of psychiatry at the University of Oslo and medical superintendent of the Gaustad Mental Hospital, Oslo.

"delayed admissions" includes patients who were admitted to a psychiatric hospital for the first time five years or more after the onset of the first symptoms. Now the statistical registration of duration is in many ways difficult. In periodic (remittant) cases only the duration of the present attack of the psychosis should be taken into account. But sometimes the mistake is made of calculating the duration from the onset of some previous attack which did not lead to hospitalization, and so an over-estimate results. In cases with an insidious course it is frequently impossible to fix a definite time of onset, and this will mostly result in an under-estimation of the duration, particularly in certain forms of schizophrenia. Similar problems arise when a psychosis develops upon a background of psychopathic personality.

In epileptic psychoses and in psychoses with mental deficiency the concept of duration is too equivocal to be of much use. According to the statistical instructions the point of departure should be the first onset of actually psychotic complications, but in practice an epileptic psychosis is often registered as having lasted since the onset of the first convulsive seizures, and idiots or imbeciles are said to have been ill "since birth." Actually many of these patients are not psychotic at all, but are committed to a mental hospital for reasons of expediency, the special institutions being too inadequate to care for difficult epileptics or defectives. In the following, therefore, these two groups are left out.

With these reservations some results of a statistical analysis are presented, the material being the national register of psychotic patients admitted to psychiatric hospitals in Norway. Among 15,452 first admissions during the period of 1936–45, 2,060 or 13% had a duration of five years

TABLE I

Percent of first admissions to psychiatric hospitals in Norway by duration of illness, in years, for the main diagnostic groups

DURATION OF ILLNESS (years)	SCHIZOPHRENIA (percent)		MANIC-DEPRESSION (percent)		OTHER FUNCTIONAL PSYCHOSES (percent)		SENILE AND ARTERIOSCLEROTIC (percent)	
	1926–35	1936–45	1926–35	1936–45	1926–35	1936–45	1926–35	1936–45
–½	25	41	51	68	41	60	26	37
½– 1	14	12	27	16	20	13	13	11
1– 2	23	13	11	8	16	10	22	16
2– 5	28	17	8	5	16	9	30	21
5–10	6	9	2	2	4	4	6	9
10–	4	8	1	1	3	4	3	6
Total	100	100	100	100	100	100	100	100

TABLE II

Percent of delayed admissions 1936–45, by diagnosis

DIAGNOSIS	DURATION OF ILLNESS			
	5–9 years		*10 years or more*	
	Men	*Women*	*Men*	*Women*
Schizophrenia	52	46	52	38
Reactive psychoses	10	17	8	13
Manic-depression	–	3	3	4
Senile and arteriosclerotic	14	16	6	10
With mental deficiency	7	6	25	22
With epilepsy	3	3	7	6
Others	14	9	9	7
Total	100	100	100	100
Number of cases	455	538	473	594

or more. The percentage distribution of these delayed admissions is given in Table II, so as to show the general nature of the problem. It is natural that nearly half of these cases should be schizophrenics: the less malignant forms tend to have spontaneous remissions before five years have passed even if they are not admitted to the hospital. The reasons for the large number of psychoses with epilepsy and with mental deficiency with a nominal duration of more than ten years are discussed above.

Table I shows that the duration varies with the diagnosis, being much longer in schizophrenia and senile psychoses than in manic depression, while the other functional psychoses occupy an intermediate position.

Apart from this a statistical analysis does not reveal many differentials, and the duration seems to be remarkably constant from one group to another. Delayed admission is about equally common in all age groups. The tendency to delayed admission seems to be independent of such factors as sex, age, marital condition, occupational status and place of residence (urban or rural). Evidently the statistical approach does not throw much light upon the problem, and a closer study of individual cases was therefore attempted.

Among the first admissions to Gaustad Mental Hospital from 1936 to 1953, 191 were registered as having a duration previous to admission of five years or more. A study has been carried out of these patients, based upon the case histories and the personal knowledge of the author. For most purposes the material has been subdivided in four main diagnostic groups:

1. Schizophrenia.

2. Other functional psychoses, including ten doubtful schizophrenics, but no manic-depressives.

3. Senile, arteriosclerotic and other organic psychoses.

4. Psychoses with epilepsy and with mental deficiency, which have been left out, for reasons previously stated.

The community of residence (Table III) previous to admission was urban or semi-urban in 61% of the cases, while only 13% of the patients came from typically remote country districts. This is practically the same as was found in a control sample of 530 patients who were admitted to the same hospital after a duration of less than six months. Delayed admissions might have been expected to be less common in densely populated areas, but actually it is quite natural that people who are "different" are just as likely to avoid detection and to be neglected here. The more tolerant attitude and the better housing facilities which are usually ascribed to the country districts are somewhat doubtful and at least far from universal.

A total of 62% of the patients lived with relatives. Only 13 were admitted from

TABLE III

Social background of patients with delayed admission

	SCHIZOPHRENIA	OTHER FUNCTIONAL PSYCHOSES	SENILE AND OTHER ORGANIC PSYCHOSES	TOTAL
Total number of cases	77	46	31	154
PLACE OF RESIDENCE				
Major cities	12	6	5	23
Small towns	18	15	16	49
Densely populated rural areas	10	6	6	22
Country districts, average	14	8	1	23
Remote country districts	14	5	1	20
Abroad	8	2	1	11
Varying and uncharacteristic	1	4	1	6
Lived alone	7	8	3	18
Lived with parents	36	9	–	45
Lived with spouse or children	7	18	17	42
Lived with other relatives	6	4	4	14
Lived in family care or nursing homes	6	1	6	13
Lived in institutions abroad	2	–	–	2
Lived in no definite residence, vagrant	13	6	1	20
ECONOMIC STATUS				
Good	15	8	5	28
Fair	32	21	12	65
Marginal	16	13	12	41
Poor	9	3	2	14
In institutions	5	1	–	6

TABLE IV

	SCHIZOPHRENIA	OTHER FUNCTIONAL PSYCHOSES	SENILE AND OTHER ORGANIC PSYCHOSES	TOTAL
Total number of cases	77	46	31	154
PROBABLE REASONS FOR DELAYED ADMISSION				
Over-protection	21	11	12	44
Neglect	25	12	5	42
Domineering patients	3	13	2	18
Prejudice	9	2	3	14
Bed shortage	5	2	5	12
Psychosis not recognized	11	6	4	21
Wartime conditions	3	–	–	3
MEDICAL ATTENTION RECEIVED				
No medical attention	47	21	9	77
Seen by general practitioner	5	13	8	26
Seen by psychiatrist	7	7	5	19
Under public care	9	4	9	22
In institutions abroad	9	1	–	10
WORKING ABILITY				
In full work all the time	9	11	–	20
In work part of the time	20	16	5	41
Occasional jobs	11	10	1	22
Peddling, etc.	7	1	2	10
Has not done any work	30	8	23	61
GENERAL SOCIAL ADAPTION				
Good	15	10	1	26
Has been a passive burden	16	8	10	34
Troublesome	26	18	16	60
Dangerous	12	9	2	23
Criminal	8	1	2	11

family care or nursing homes, which is remarkable in view of the fact that in Norway nearly 50% of the insane have to be cared for outside of mental hospitals. Evidently most patients suffering from a psychosis have at least for some time been hospitalized during the early stages of the illness. And if such cases are placed directly in family care (which is in no way uncommon), the difficulties which necessitate hospital admission are likely to arise before the first five years have passed.

Twelve percent of the patients had lived alone previous to admission. An additional 13% (most of them suffering from schizophrenia or allied conditions) had been living more or less as vagrants. It may be concluded that delayed admisison is not particularly common in lonely persons, but is more likely if the patient has somebody who can take care of him.

The economic status of the patients and their relatives seems to have been somewhat below the average, but nevertheless 60% have enjoyed a good or fair standard of living. A study of individual cases indicates that such average figures are misleading, because favorable as well as unfavorable social conditions can, each in their own way, lead to delayed admissions. On the whole the economic factor does not seem to be of primary importance.

Our classification of the probable reasons for the delay in admission (Table IV) is naturally nothing but a rough estimate, based upon factors which are obvious by a superficial examination of the social situation. Here again, as with the economic factors, we find a highly mixed etiology, over-protection being about equally common as neglect. In 18 cases—mostly psychopaths with paranoid, hypochondriacal or hysterical reactions—the patient avoided admission by his tyrannical attitude in the home.

Definite prejudice against mental hospitals seems to have been the main cause in only 14 cases, which is rather encouraging. Most of these patients were comparatively young and staying with parents, or they were housewives. The most typical situation is that well-to-do middle-class parents refuse to have their psychotic son admitted, in spite of full knowledge of the medical facts, while such instances are very rare among the female patients. One patient was a medical student, and another was the son of a mental hospital official. One paranoid woman was extremely hostile towards psychiatrists because her son was in a mental hospital with a severe catatonic deterioration, but this is the only case in which previous contact with the mental hospital system has activated prejudices and led to delayed admission.

Lack of hospital accommodation is given as the main reason in 12 cases, which indicates that in spite of the serious bed shortage very few psychotics are in the long run kept out of the hospital system.

In 21 cases the psychosis was not recognized as such by the patient or by anybody in responsibility, 11 of these patients being schizophrenics.

It is remarkable that 50% of the patients are not known to have had any medical attention for their mental condition previous to admission. For schizophrenics the percentage is 61. Clearly most psychotics who are actually seen by a doctor will avoid delayed admission.

In the senile-organic group 74% of the patients were totally incapacitated, and not a single one was able to do regular, full-time work. Among the patients with functional psychoses 16% were actually self-supporting until their delayed admission and only 31% were incapacitated most of the time. Clearly working ability helps to keep a psychotic out of hospital, but it is not a decisive factor.

The same seems to be true of the general social adaption of the patients. A majority were more or less heavy burdens upon their relatives and upon society, 39% were characterized as decidedly troublesome and 22% even as threatening and potentially dangerous or criminal. Frequently one gets the impression that the relatives sacrifice a great deal in order to keep such a patient at home.

A total of 11 (eight of them schizo-

phrenics) had committed crimes, but in no case was the charge very serious: drunk and disorderly, disturbing the peace, pilfering, vagrancy, etc., mostly several times through a period of years. It is remarkable that acts of violence or other serious offenses are not registered in the entire material, probably because such acts are more likely to be committed during the initial phases of a psychosis and then, naturally, result in immediate commitment. The most serious case was a senile man with persecutory delusions who for years had kept a knife under his pillow, much to the distress of his wife.

While many of the patients have represented serious social and personal problems to their relatives and immediate surroundings, very few seem to have suffered much themselves—at least, not in the way of overt neglect. The mental sufferings are naturally very hard to judge. The clearest case is that of a senile woman who lived alone on a small independent income for twelve years with a slowly progressing deterioration, until her landlady found it necessary to notify the authorities. The patient had then been without fuel for one whole winter and was in a bad shape.

In 60% of the cases the initiative towards admission was finally taken by the next of kin, which is the regular proceeding in Norway. In 36% the authorities took the necessary steps, but this was generally because the patient had gradually lost contact with his relatives or because they could not be found or contacted. We never hear that the authorities have taken over because the responsible relatives have neglected their duties or against their protest. This does not mean that such neglect has not been clearly evident in a number of cases, but generally the proper authority (which according to the law of lunacy is the police) does not enter into the picture unless the patient is suspected of being a menace to public safety or grossly mistreated. If these patients had any relatives at all, they were generally treated with the utmost care and consideration. Nevertheless, one feels that it would in several cases have been better if law and custom had allowed a more active attitude on the part of the proper authorities—for instance, on the ground that the patient did not get proper treatment and that consequently chances of recovery were being reduced.

In four cases the patient himself applied for admission, while in single instances an employer and a landlady took the initiative. Mostly no particular reason is given for the final admission, except the progression of the illness, which made the social problems increasingly difficult. Frequently the admission came when the person who had carried most of the burden had to give up or died. Married siblings will not easily take over the responsibility which the parents carried willingly.

A description of the pre-psychotic personality (Table V) is given in 86% of the total material. No doubt the information is sometimes inaccurate because of the prolonged duration of the illness. Among the 132 cases in which a personality description is given, only 26% are described as having been fairly normal, balanced and average, while 74% were more or less deviating types: 41% of the schizoid variety, 24% self-assertive, impulsive or otherwise active and stenic as against merely 7.5% of the sensitive and depressive types. This excess of personality deviations, mainly in the schizoid direction is probably directly connected with the delayed admissions: an unusual personality makes early diagnosis of an insidious psychosis more difficult, because initial symptoms and pre-psychotic personality traits are so easily confused. It is quite natural that the potentially a-social

and anti-social traits should predominate, while sensitive and depressive types are much less predisposed towards delayed admission.

The onset and the course of the illness has in most cases been insidious and slowly progressive. Really acute onset was found in six cases only, and in 11 the onset may be characterized as sub-acute. Evidently an acute onset is highly effective in preventing delayed admission (which, by the way, is the obvious explanation for the more favorable prognosis which is generally ascribed to such cases, with or without special therapy). In 20% of the functional cases there had been previous acute attacks that had not led to admission. The initial symptoms were mostly not particularly suggestive of insanity: gradual change of character, neurasthenic and depressive traits or mild ideas of reference. In 8 schizophrenics religious preoccupation was the first symptom, with revivals and nonconformist activity rather than exaltation and messianic ideas. Impulsive behavior and temper tantrums were uncommon, and so were transitory periods of confusion or excitation.

A classification according to the predominant syndrome during the years previous to admission shows that paranoid and paranoic pictures are most common, with 44% of the total. Hebephrenia comes next with 23%. Among the paranoids the female patients are more common (39 as against 24 men), while the opposite is the case in the hebephrenic group (25 men and 9 women). It is natural that the male paranoids should be regarded as potentially more dangerous than the women, but why the male hebephrenics should be predisposed towards delayed admission is more obscure.

Depressions, excitations and hysterical pictures are comparatively rare among the delayed admissions, partly because such symptoms tend to be so disturbing that an early admission can hardly be avoided and partly because these syndromes are more unlikely to become chronic.

The depressives were in most cases chronic hypochondriacal invalids, some of them with obsessive features, who at long last had to be regarded as psychotic for practical reasons. Suicidal tendencies were lacking, because they would have led to earlier admission, but otherwise these patients have represented heavy burdens upon their relatives: grown children shun the home, servants will not stay, etc. Nevertheless, these patients are emotionally appealing, and this may be the main reason for the delayed admission. Pre-psychotically they were generally somewhat rigid, headstrong personalities used to dominating their environment, and in the clinical picture no feeling of guilt was evident.

Among the paranoics all the known types are represented: one case of paranoia erotica, against whom the victim at last had to seek police protection; one sensitive type with compulsive traits; another sensitive paranoia on the basis of chronic alcoholism; a compensation neurosis who develops into a querulant; a neurotic and alcoholic invalid who is a "difficult man" but hardly psychotic in his feelings of being persecuted; a psychopathic teacher who gets into constant trouble with pupils, parents and school authorities; a hypochondriacal psychopath who is "persecuted" by the health authorities; a chronically hypomanic type who finally gets his own back as a Quisling during the war, etc. Of particular interest is an induced psychosis, developed in a woman who was in family care with her schizophrenic sister. Some of the paranoic syndromes were most likely on a schizophrenic background.

The paranoid cases are generally of the

TABLE V

	SENILE AND OTHER ORGANIC PSYCHOSES	SCHIZOPHRENIA	OTHER FUNCTIONAL PSYCHOSES	ALL FUNCTIONAL PSYCHOSES	
				Delayed admission	*Early admission*
Total number of cases	31	77	46	123	126
PRE-PSYCHOTIC PERSONALITY					
Schizoid	6	37	12	49	24
Sensitive, depressive	–	4	6	10	32
Unstable, impulsive, hysterical	3	6	12	18	17
Self-assertive	3	2	6	8	8
Normal, balanced, average	11	17	7	24	32
Not sufficiently known	8	11	3	14	13
COURSE OF ILLNESS PREVIOUS TO ONSET					
Acute onset	3	1	2	3	38
Subacute	2	5	4	9	34
Insidious, with exacerbations	4	15	11	26	17
Insidious	21	55	22	77	17
Episodic, periodic	1	1	7	8	20
INITIAL SYMPTOMS					
Change of personality	11	21	13	34	10
Neurasthenic, psychosomatic	4	13	10	23	24
Ideas of reference	–	12	10	22	21
Depressive	3	6	6	12	22
Religious preoccupations	–	8	–	8	8
Impulsive behavior	1	2	3	5	13
Transitory episodes	–	3	1	4	11
No particular initial symptoms	12	12	3	15	17
PREDOMINANT SYNDROME					
Paranoid	5	33	8	41	26
Paranoic	–	3	19	22	10
Hebephrenic	1	34	–	34	23
Catatonic	–	6	–	6	16
Hysterical	2	–	10	10	9
Depression	1	1	6	7	27
Excitation, confusion	1	–	3	3	15
Organic deterioration	21	–	–	–	

• In the last two columns the delayed admissions are compared with a representative sample of early admissions (within six months) to the same hospital.

paraphrenic type, comparatively normal and unobtrusive in behavior and speech, and with a very slowly progressing deterioration. Neither the paranoics nor the paranoids have been dangerous or seriously threatening, and most of them not even particularly troublesome.

The so-called hysterical group is comparatively uniform. Only two or three of the 12 had ever presented psychotic symptoms *sensu strictori,* and then only as brief episodes of excitement and confusion. The others were actually psychopaths, who were committed more or less for practical reasons, because it was no longer possible to tolerate their behavior, and because no other institution was able to cope with them. Relatives, neighbors and authorities have in these cases shown a striking patience, sometimes an actually helpless attitude which has helped to cultivate and aggravate the hysterical symptoms. None of these patients was dangerous. Three were alcoholic, one was an occasional thief, and another a tuberculous vagrant who was a menace as a source of infection.

The therapy may be called supportive psychotherapy but was largely a matter of regime and discipline, and in most cases the results were good. Social rehabilitation outside of the hospital presented many problems, however.

It is generally agreed that the result of psychiatric treatment is dependent upon the duration of the illness. In the present material with a minimum duration of five years, 36% of the schizophrenics and 59% of the other functional psychoses could be discharged to their home or to an independent existence, and less than one in ten had to be re-admitted (Table VI). No doubt a longer period of observation (it varies between 3 and 20 years) and a personal follow-up examination would show that in these cases discharge does not always mean social remission or cure. Nevertheless, the results were better than expected. Active therapy (ECT was used in most of the functional cases, and leucotomy in some) may have contributed. But the main factor is probably the attitude of the relatives, which in these cases has been particularly favorable. Also the very fact of a delayed admission indicates that the patient has a certain ability to adjust in spite of his chronic psychosis. A total of 22%

TABLE VI

Outcome of hospital treatment after delayed admission

	SCHIZOPHRENIA	OTHER FUNCTIONAL PSYCHOSES	SENILE AND OTHER ORGANIC PSYCHOSES	TOTAL
Total number of cases	77	46	31	154
RESULT OF TREATMENT				
Discharged, to relatives or independently	28	27	7	62
Same, but re-admitted	5	1	–	6
Discharged to family care	21	13	7	41
Chronic in hospital	17	2	6	25
Died in hospital	6	3	11	20

TABLE VII

Outcome of treatment in delayed admissions 1936–45 to all psychiatric hospitals in Norway

	NUMBER OF CASES	RESULTS PER 100				
		Good	*Fair*	*Poor*	*Died in hospital*	*Total*
Schizophrenia	909	10	7	73	10	100
Reactive psychosis	252	41	10	44	5	100
Manic-depression	53	44	9	38	9	100
Senile and arteriosclerotic	233	2	4	43	51	100
Epileptic and other organic	160	19	9	50	22	100
Confusional and others	43	40	7	37	16	100

of the schizophrenics are still in the hospital, mostly as deteriorated chronics, but as a group they are not among the most troublesome patients, and most of them take active part of occupational therapy.

Speculations about what might have happened if these patients had been admitted at an earlier stage are futile. Nevertheless, the author has tried to form an opinion based upon clinical judgment, and has come to the result that about half of the functional cases would probably have benefited from an earlier admission, while the remaining cases are more doubtful. In the non-functional group nothing much has been lost. In quite a few cases it is our impression, however, that the patient would probably have been easier to care for in the hospital if he had come under regular hospital regime in the initial stages of the illness.

In Table VII a survey is given of the results of treatment in all delayed admissions to mental hospitals in Norway from 1936 to 1945. These figures, which are based upon the condition of the patient rather than upon the place to which he was discharged, are less encouraging, but nevertheless they confirm that good or fair social readaption is far from excluded even in these supposedly neglected cases.

SUMMARY

A clinical study was made of a group of 191 patients who were admitted to a mental hospital in Norway after a duration of the illness of five years or more. The reasons for such delayed admissions were partly to be found in the attitude of relatives (overprotection being more common than neglect) and partly in the clinical picture of the psychosis. Most of the patients have not suffered much, and public order and safety has to only a limited extent been endangered, but the burden has often been very heavy upon the relatives. The results of the delayed hospital treatment were better than might have been expected.

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PAUL KIVISTO

Treatment of sex offenders in California

Seven years of work among the mentally disturbed in California institutions have brought before me the need of the American public to know more about its social troubles and how they are handled. Where prejudice and feelings run high, reasonable examination of causes and effects are most difficult. In the interests of an enlightened public, I am presenting one of the most difficult of social problems that has bothered the conscience of man.

The highest percentage of sex offenders arraigned in California courts are child molesters, men accused of sexual activity with minors. Before 1946 such men were imprisoned from 5 to 10 years, then released to inflict their disorder again upon the public. The rate of repeated sex crimes was appalling and the expense of incarceration high. It was evident that some new approach to the sex offender was needed. Since punishment and imprisonment was not the answer, psychotherapeutic measures were tried. Although child molesters made up the majority of sex offenses, there were other deviates who could also benefit by a treatment program—such as homosexuals and exhibitionists, legally defined as sexual psychopaths.

As a result of study and experience it has been found that the average sex offender is the result of social disorganization in the family from which he came. Divorce, loss of one or both parents, crime, alcoholism, mental illness, delinquency are common features in the family of the offender. Emotions such as anxiety, guilt, depression, in-

Mr. Kivisto is senior clinical psychologist at Atascadero State Hospital in California.

adequacy appear as central disturbances in his make-up. He is highly influenced by the tempo of modern life, his judgment collapsing when he is faced by the tensions of pressing obligations and suspicions. He faces chronic humiliation and loss of self-esteem as a result of his poor judgment, which follows from his essential emotional confusion. Thus the vicious circle of humiliation, hatred and confusion becomes so intense that an ill-considered act occurs.

Socially speaking, the sexual offender is an isolate. He has deep anxieties within a group of people and among women. He is unable to see himself as a man and as an adult. Any degree of responsibility shatters him to the point of helplessly demonstrating his failure to other people. His childish fumbling sexuality appears to be only one of many expressions of personal incertitude.

The usual sexual offender is married, has children of his own and is a productive member of the community. It is economically sound to treat him so that he can return to a productive existence. The cost of providing for his family indefinitely is a strain upon the community resources as well as an emotional privation to his family. Without treatment his marriage is ridden with misery and conflict. Such a person tends to marry a woman older than himself. In many cases the wife is better educated and more competent, and is the dominant member of the relationship. In the husband's more aggressive and self-assertive moments he competes with his wife only to become upset and confused. Struggle for manhood in the neurotic male appears to be interminable, and he is alternately resigned and then over-compensatory as seen in such acts as philandering, overwork, and endless worry over failures and successes.

Over the last two years more than 1,000 such emotionally disturbed sex cases have been sent from the California courts to Atascadero State Hospital. Each case has been observed and examined by the staff to determine the nature and degree of emotional disorder, and possible treatability. Of those accepted for the program and subsequently returned to the community after treatment, it has been estimated that 9% have repeated a sexual offense.

Other than anti-social and neurotic personalities, the hospital also has facilities for the so-called criminal who becomes psychotic before the execution of his sentence, and for the offender who successfully pleads not guilty by reason of insanity. Maximum security is provided for these men as well as for other psychotics, known also as the legally insane. Since the estimates of legal insanity among sex offenders run from 4% to 11%, such cases are in the minority. The heinous sex crime is the product of the psychotic personality, not the act of the emotionally disturbed person who is legally sane before and at the time of the sexual act.

The program at Atascadero State Hospital provides every opportunity towards individual, emotional, religious and social growth. Considered as a therapeutic community, the hospital exposes the new patient to social interaction in group therapies, group projects, patient government, educational classes, lectures by the staff and patient discussion groups. Each man receives complete physical, psychiatric and psychological examinations, and is assigned to a psychotherapist who can also provide individual counsel. As the time of hospitalization increases to the 15th month, marked personality changes appear in the patient. He has worked through his earlier hostilities and anxieties, is relaxed, helps in the program, devotes understanding and help to the newly admitted fellow patient.

Finally he meets the scrutiny of the outgoing staff examination with a smile, a sense of self-mastery and a clarity of judgment he never believed possible in himself.

Such is the difference between this man and his future in contrast to what long years of imprisonment have failed to do. Christian treatment, emotional insight and development and the transformative effect of personal growth demonstrate, every day of the program, that our social problems have emotional origins of hatred and resentment. Such emotional problems can be treated with demonstrable effectiveness in helping disturbed men become human beings capable of loving life and of contributing to their families and communities, and without repetition of their crime.

MORRIS M. PAULEEN, PH.D.

A training experience in interpersonal relations for psychiatric technicians

This paper describes an experimental project involving a modification of philosophy and method in one part of the training program for psychiatric technicians at the New Jersey Neuropsychiatric Institute, a state in-patient facility concerned with the treatment of various types of neurological and psychological disorders, with emphasis on research and training functions. The change consisted of a shift in approach from a traditional, academic presentation of course material in psychology and mental hygiene to an attempt to involve the trainees in a dynamic group experience emphasizing spontaneous group discussion of personal, work and intra-group experiences and reactions of the members, with course material brought in and discussed only as it could be meaningfully integrated with the ongoing group processes. The objective of the project was to use the group experience to stimulate in the trainees increased awareness and understanding of the role played by intra-psychic and interpersonal factors in their lives and work. It was hoped that greater self-insight and psychological understanding growing out of the group experience would contribute to a more mature and better directed ability to handle personal and work responsibilities and problems.

BACKGROUND

Among the more significant modern developments in the field of mental health has been the recognition of the basic role played by psychological and social factors

At the time he wrote this article, Dr. Pauleen was director of psychology at the New Jersey Neuropsychiatric Institute. He is now with the Mid-Nassau Community Guidance Center in Hicksville, Long Island, N. Y.

in the formation and expression of human personality and behavior. One valuable result is evidenced in our increasing ability to utilize and manage psycho-social forces to facilitate change and growth in people whose life patterns are characterized by psychological and social immaturity or disturbance. Among institutions responsible for dealing with the problem of the severely disturbed, these developments have influenced a trend of basic change in philosophy and method. The traditional approach based on physical custody and care is slowly giving way to the concept of creating therapeutic communities where atmosphere, practices and patterns of human relations are logical developments of the belief that human beings can re-learn to perceive and interact with their interpersonal world in a more effective and self-fulfilling way.

It is commonly recognized that the key to the growth and success of such a therapeutic community is a staff whose members, understanding the theory and techniques of interpersonal relationships, themselves possess the personal qualities needed to form and foster constructive human relationships within the community. Among the staff, the importance of the role of psychiatric technicians and attendants, who are unique in their direct and continuous contact with the patients, cannot be overlooked. Schwartz and Shockley, in their recent book *The Nurse and the Mental Patient,* state accurately: "These personnel form emotionally important relationships with patients, make up their social environment, and leave their mark on them for good or ill. Through these relationships personnel can make a significant contribution to an improvement in the patient's living with himself and others."

The problems faced by the New Jersey Neuropsychiatric Institute in effectively selecting, training and integrating ward personnel as valued contributing members to a viable psychotherapeutic program are well recognized and are essentially those met by any institution undertaking the change from a custodial to a therapeutic orientation. Poor rewards and difficult working conditions offer poor inducement to potentially good applicants. Traditionally low status and routine menial duties discourage interest and involvement in the work. The prospect of basic changes in responsibilities and relationships understandably stimulates anxiety and resistance among professional and nonprofessional staff alike. Success in developing an effectively cooperating staff with a common understanding of problems, goals and methods involves a patient, multifaceted approach to the many problems encountered. This paper describes an attempt to develop a contribution to the solution of some of these problems by an experimental modification of philosophy and technique in one part of the training program for psychiatric technicians.

THE PROJECT AND ITS METHODS

The psychology department of the institute participates in the psychiatric technician training program, teaching courses in psychology and mental hygiene to junior trainee groups. The courses follow outlines set up by the Bureau of Personnel of the State Department of Institutions and Agencies and until the spring of 1956 were based on textbooks recommended by the bureau. Until that time teaching techniques followed the usual lecture method aimed at the academic presentation of course material, with the instructor answering questions from class members and giving periodic examinations to evaluate learning of the subject matter.

It was the common observation of those staff members who participated in these assignments that (1) the scope and presentation of the textbook material was inappropriate for the student technicians, (2) the students' learning and understanding of course material, as gauged from classroom discussion and examinations, was unsatisfactory, and (3) the students evidenced minimal interest and involvement in the courses. It was our belief that these deficiencies were not the result of an intrinsic lack of value or interest in the course matter, but rather of a failure to consider realistically the personal and work needs, interests and capacities of the students and to plan the training experience in light of these considerations.

Accordingly, in April 1956 the objectives and methods for the psychology and mental hygiene courses offered the new training class entering at that time were revised as shown below.

OBJECTIVES

1. To present course material in a way which would stimulate the interest, serve the needs and conform to the capacities of the trainees, while following Bureau of Personnel outlines.

2. To present the material in a manner which would make it personally meaningful to the trainees and help them to assimilate it for constructive use in living.

3. To stimulate in the trainees an understanding of human behavior, its roots and its meaning; to help them perceive and understand the patients' behavior as *human* behavior related in derivation and purpose to their own, as to all human behavior; to help dispel ideas and feelings that patients are alien beings to be feared, despised or otherwise "used" by staff members.

4. To facilitate group discussion of personal and work problems and to help the trainees work through these problems constructively and with increased insight of self and others, with consequent benefit to the trainees and the institute.

5. To help establish an early precedent for better understanding and freedom of communication between professional and non-professional staff as mutually contributing partners with a common goal.

METHODS

1. New textbooks selected for clarity, interest and pertinence were chosen for reading background: Bernhardt's *Practical Psychology* for the psychology course and Kraine's and Thetford's *How to Manage Your Mind* for the mental hygiene course.

2. Meetings, scheduled for two hourly sessions per week over a period of six months, were conducted as round-table group discussions aimed at fostering maximum personal involvement by group members.

3. Reading matter, when brought up spontaneously by the group, was discussed by the group primarily in relation to its significance to the ongoing personal and work experiences of the members as these came out in the meetings. The group leader, although supplying factual information when indicated, generally gave the group the responsibility for bringing out opinions and feelings about what was being discussed. The group leader also on occasion summarized and clarified the opinions and feelings brought out and, when indicated for the progress of the group, offered dynamic interpretations relating to material discussed and to interpersonal processes in the group. The pertinence of course materials to the group experience was indicated when appropriate.

4. Brief weekly quizzes on course material

were given. Discussion of this material, as well as of the trainees' reactions to the quizzes, was part of the regular group sessions.

PROJECT EVALUATION

Results of the project were evaluated by both trainees and the group leader. The students' views were elicited by a course evaluation form patterned after one used by the Menninger Foundation in its experimental psychiatric aide training program. The unsigned forms were designed to allow the trainees to give their evaluations and opinions frankly and anonymously. There were 10 students in the group. A summary of their evaluations and verbatim sample comments are given below.

Psychiatric Technician Course Evaluation

(Summary)

N.J.N.P.I.

This form has been devised to obtain your assistance in improving the course in psychology and mental hygiene for the students of future classes. In each category, please check the response which you deem most appropriate. Your recommendations are important in this evaluation. *Please do not sign the form.*

I. Content of course

A. Level of instruction
   1. Too elementary 0
   2. Too advanced 1
   3. Right level 9

B. Implications of course matter for technicians
   1. Overstressed 0
   2. Insufficiently stressed 3
   3. Properly stressed 7

C. Scope (amount) of instruction
   1. Too broad 1
   2. Right scope 6
   3. Too narrow 3

D. Appeal of course content to you
   1. Interesting 10
   2. Dull 0
   3. Neither 0

E. Applicability of course content to your everyday work
   1. I am able to apply most of the course content to my work 3
   2. I am able to apply some of the course content to my work 7
   3. I am unable to apply any of course content to my work 0

F. Please evaluate frankly the importance or unimportance of this course to your over-all training. (Specify how it has or has not been of use.)

Typical responses given:

The over-all importance of this course is, I feel, that it has clarified the thinking of all the class members. It has given a more realistic attitude toward the work involved in dealing with emotionally disturbed patients, a clearer understanding of our own behavior in relation to the people we deal with, a deeper insight into the problem of mental health.

This course has been very helpful to me in understanding other people and myself. And in understanding myself, I have been able to understand others better. It has taught me, in doing for other people, to stop and think how would I want this thing done for me or to me. Putting myself in their place for a second makes me realize they are not only patients but a person and an individual and I try to treat them as such.

Important. I have learned to work better with my co-workers. I think I'm better liked by the people I work with. I've always got along with the patients. I find now, with people I work with, I'm not so blunt or frank in what I say. I find myself being quite considerate of the other fellow's feelings.

This course is of great value and can be used to avoid at times a great many problems that may come up during the time we spend on the ward. Even in our homes it comes in very handy.

G. Do you feel that added training along similar lines would be of use to you and how?

Typical responses given:

Our class wanted to have one hour a week or every other week for discussion. We feel this is very important to us because it would be a good place to let off steam or iron out difficulties that arise in our work. Sometimes incidents happen and we may not know how to cope with them. To go to your supervisor immediately without forethought can cause unnecessary confusion. By discussing these at a round-table discussion with the rest of the class, many incidents have been squashed at discussions when proven minor by the class or Dr. Pauleen.

Yes, I do. Because these are things or problems that come up in our daily work which seem to be very large, but if there was someone with whom we could discuss the problem I think we could solve it ourselves without a lot of dissatisfaction on our part and others. Sometimes we make a problem larger than it is, but after talking about it to someone we see it as something very small and childish.

Yes. Additional training along these lines would enable me to handle situations with which I am unfamiliar more capably and correctly. For example, in child behavior if the child is preparing or is in the act of creating a disturbance, do you: Threaten him with loss of privileges? Ignore it? Scold him? Or use physical control? How do you get a withdrawn patient back to normal activity and keep him there?

II. Instruction

A. Rate of instruction

1. Moved at right rate	5
2. Too slow	0
3. Too rapidly	5

B. Lecture and discussion

1. Not enough discussion	2
2. Right amount of discussion	8
3. Too much discussion	0

C. Instructor's ability

1. Excellent	4
2. Good	6
3. Fair	0
4. Poor	0

Why? (Sample comments)

Because he will try to let you solve your own problem first, then he tells you or points out the way it could have been handled in a different manner without hard feelings to anyone.

He is interested in people; their feelings about their work, and their own personal feelings and activities.

Explanations were quite understandable. Lots of interest in group. Gave ample time for individual to express himself.

D. Amount of student participation encouraged in class

1. Too little	1
2. Too much	0
3. Adequate amount	9

Recommendations (Typical responses)

The course be extended throughout the whole training year. Material be included or emphasized on abnormal psychology. Use of visual aids, and discussion of film topics. Encourage actual application of material covered. For example, if defense mechanisms are under discussion, class members could be encouraged to try various methods and report on the reactions.

I think it would be of more use if the subject were more related to the work or more inclusive. The time allotted is not sufficient to cover the material.

I recommend that the technicians be given time during the year they are in training to have weekly or bi-weekly discussion, to talk over various problems they may have. Sometimes just talking and getting things off your chest helps a lot. I think in anything you do a little pep talk or encouragement helps. On a job of this type one needs to keep their motivations alive. In any job, in time money becomes the secondary part of the job. Your satisfaction in doing a good job means everything.

The expressed opinions of the trainees indicates that, assessed from their viewpoint, substantial achievement of project objectives was realized. Course material assimilated during the group sessions was experienced as interesting and meaningful, as well as pertinent and useful in their work and everyday life. Some appreciation of the common psychic roots of human continuing the meetings after the complemotivation and behavior is apparent and also their belief that this understanding influenced their perception of and reaction to their work. Apparently the group sessions were seen as providing a welcomed opportunity to express, discuss and work through many of the personal and work problems that arose during the course of training. Evidently the trainees felt secure enough in the group to be able to express with relative comfort and spontaneity positive and negative feelings and thoughts about work and their co-workers in discussion with a normally "suspect" professional staff member.

From the group leader point of view, the group made good progress, both in the learning of the academic material, as evidenced in discussion and examinations, and in assimilating a significant amount of the material for practical application. The suspiciousness and constraint of expression which marked the group for a considerable initial period were gradually replaced by an increasingly free flow of ideas and feelings, both positive and negative, related to persons and situations inside and outside of work, and by a growing ability of the members to bring out, assess and resolve the material being discussed, effectively analyzing the reality factors and the personal and "distorting" factors involved. The trainees' ability to do this with their everyday experiences and reactions in life and work appeared to make the academic material more meaningful, and there was a progressive increase in their ability to spontaneously relate course material to new life situations.

Although earlier experiences indicated that previous technician classes had not evidenced much interest in this course, the group did become involved in the experience and expressed spontaneous interest in

tion of course work. Because the training schedule did not allow time for such meetings, voluntary group meetings during off-duty hours have continued, as scheduling permits.

Another evidence of increased interest in the work and of better staff relations was apparent in the group's willingness, on several occasions after course completion, to participate in research studies on their own time and at considerable inconvenience to some of the members. Here again previous experiences had indicated that attempts to utilize technicians and attendants in research projects often met with hostility and resistance in these groups. The development of staff members interested in participating in and contributing to research must be considered one worthwhile goal in training.

The members of the group expressed their opinion during the final course meeting that the opportunity to discuss freely and to resolve emotionally charged work experiences had been an important factor in preventing the drop-out of members through the training period, in contrast to experiences with earlier classes. It is of course difficult to assess this belief objectively. It may be noted, however, that reports from other settings where group therapy has been introduced as an adjunct to training indicate that significant decreases in turnover and drop-out generally do result. This would be an important factor in settings where turnover poses a significant therapeutic and economic problem.

DISCUSSION AND CONCLUSIONS

The trainees made apparent progress during the group experience, and results of this initial project are encouraging. Several factors undoubtedly contributed to the positive nature of this experience for the trainees. For one thing, it offered them an opportunity to learn interesting things about themselves and their work in a spontaneous and vital interactive setting. It also represented a fairly unique experience in their training where interest was centered upon them as individuals and on their needs, ideas and feelings, rather than on overwhelming arrays of technical terms and ideas. What a trainee thought or felt may not always have been agreed with, but it was listened to and discussed with respect by the group. Certainly this aspect of the experience contributed to feelings of self-worth and security among the group members, and made it easier for individuals to modify or give up erroneous ideas with a minimum of negativism or feelings of lowered self-esteem. The cathartic purposes served by the sessions should also be mentioned.

Another important facet of the experience involved the strong positive transference feelings that developed among group members and towards the group leader. Undoubtedly, a significant part of the group's reactions to the interpersonal aspects of the experience, to the factual material discussed, and to the experience as a whole was a function of transference phenomena. Unfortunately the 6-month training period was too brief to permit a fuller development and working through of this aspect of the experience and a consequent richer realization of the personal growth potential of the experience. It would seem worth while to consider scheduling time during the entire training year for a regular continuing group experience where trainees could be helped to bring theory out of the textbook and the lecture room into meaningful relationship to their own thoughts, feelings and experiences. Similar training possibilities as a part of

in-service training should also be considered.

Results with this first group were promising enough to justify the continued training and research effort along similar lines which is being carried on at the institute. Attention to identification and objective evaluation of significant attitude and personality changes among group members as a function of the group experience is being stressed, and increased interdisciplinary cooperation with nursing service on planning and evaluation is being developed. It is anticipated that the ability to objectively assess such personality factors will permit more controlled research into the relative effectiveness of various training approaches, as well as suggest improved bases for selection of training candidates. Continued investment of effort in this area is worth while, since the effective development and use of nonprofessional personnel is one of the more promising approaches to the problem of increasing therapeutic opportunities for patients.

EUGENE E. LEVITT, PH.D.

On locating closed clinic cases for follow-up studies

About half of the studies of the outcome of psychotherapy employ the procedure of following up and evaluating a group of cases some years after the close of treatment. The group is often a sample of cases treated by some agency, and the length of the interval between the close of treatment and follow-up depends upon the sampling approach. For example, the investigator who wishes a 5-year interval will sample from among cases closed five years prior to his study. When one of the purposes of the study is to assess the relationship between outcome at follow-up and elapsed time since the close of treatment, it will be necessary to have a number of different intervals.

Location of the persons in the follow-up sample is invariably a sticky problem, for obvious reasons. It is also obvious that the number of cases which can actually be located will vary inversely in some fashion with the length of the interval. This creates an additional complication if the design of the study requires approximately the same number of cases, or a specified minimum number, at each interval.

It would be helpful to have some idea, however crude, of the anticipated number of locatable and unlocatable cases as a function of interval. The investigator would then be guided in determining the return which can be expected for his efforts and he would be able to estimate how many cases must be sampled to find a given number. Such estimates are likely

At the time this paper was accepted, Dr. Levitt was director of research at the Illinois Institute for Juvenile Research. He is now chief of clinical psychology at the Indiana University Medical Center and associate professor in the department of psychiatry of the I. U. medical school.

to be of most value when the study has a predetermined duration as in grant- or contract-financed research, or when resources are otherwise limited and economy is a salient consideration.

Any estimation of locatability must, of course, be based on empirical data. Since these will probably vary as a function of the type of patient, the nature of treatment, the intensity and kind of efforts aimed at locating cases, and sundry other variables, reports should include an account of these factors.

This paper is a report of locatability and time interval in a follow-up study of patients at a large community child guidance clinic in Chicago. The sample was divided into two sub-groups: one of cases which had been accepted for treatment but had subsequently refused it and thus had never been treated at the clinic; the other of cases in which either the mother or the child had received at least five treatment interviews. There were 427 cases in the first group, which is designated as Group I, and 579 in the other, Group II—a total of 1,006. There were 13 instances in which two or more children of the same family were included, and since we are concerned with locatability we shall use the family unit rather than the case unit. The frequencies are then 426 for Group I and 566 for Group II, making 992 families.

The total sample represented a random selection of about one-third of the cases of these types which were referred to the clinic during the period January 1, 1944 to December 31, 1954 inclusive. All but a few of the families resided in the Chicago metropolitan area at the time of referral.

The location procedure began with a form letter explaining the purpose and operation of the follow-up study. A return postcard was enclosed for the family's response. If the letter was returned undelivered by the post office, a careful search of the case record and the telephone directory was instituted. When a new address was found, a second contacting letter was sent. If this failed or if no new address could be discovered, there was resort to three further procedures:

1. A letter was sent to the school which the child attended when last in contact with the clinic if the child was then of school age. The letter requested the last address of record or the school to which the child had transferred. If there had been a transfer, a letter was sent to the second school, and so on.

2. A check was made of the records of the Chicago Social Service Exchange, a registry of cases having contact with all family service agencies in the area. This was tried out with a pilot group of 59 cases, but was abandoned when it proved generally unsuccessful.

3. A check was made of the motor vehicle operator's license bureau in the state capitol. Somewhat greater success with this source might have been obtained if its records had become available earlier in the study. As it happened, the tracing period had to be terminated before the information furnished by the bureau could be fully exploited.

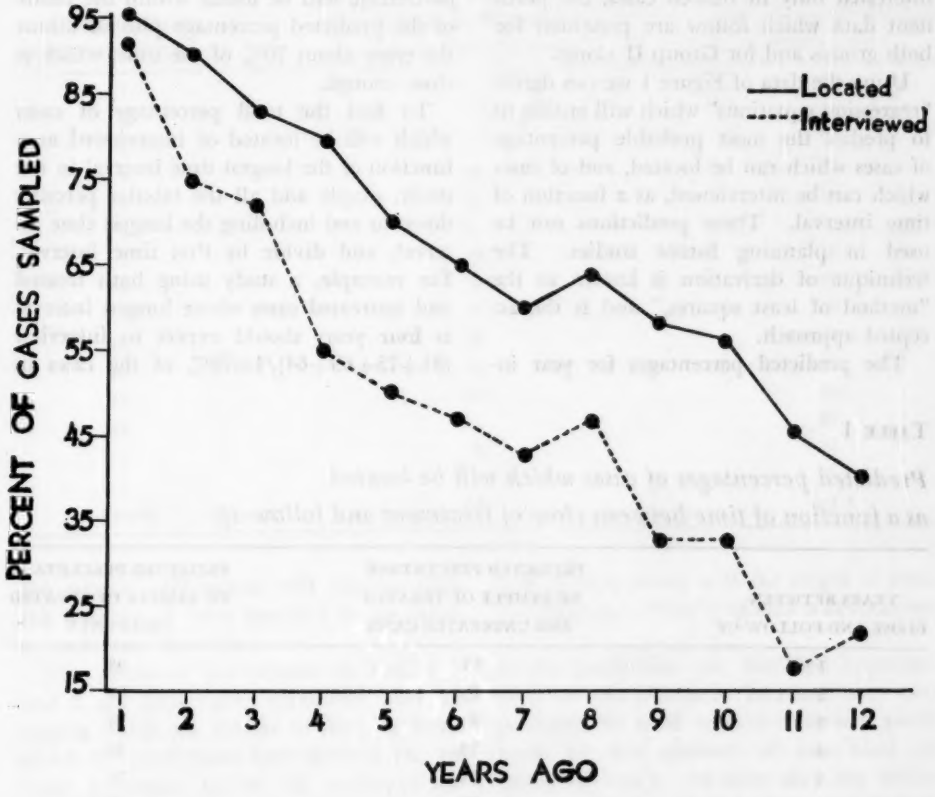
In instances where neither the contacting letter nor the enclosed postcard were returned to us, the case was turned over to a special worker who made efforts to reach the family by telephone.

Efforts to locate cases began in May of 1956 and ended in October of that year. This six-month period was all that the expedients of the project permitted.

Frequency polygons showing the percentages of cases located and interviewed as a function of time interval are presented in Figure 1. The curves reveal a clear linear trend, that is, a tendency for the

FIGURE 1

Frequency polygons showing percentages of cases located and interviewed as a function of time between close of case and follow-up



percentages to decrease regularly per year of interval. (The irregularity of the plot is no more than is to be expected because of the relatively small number of cases at each year point.) The concordance of the curves indicates that location and interviewing are highly correlated. The rank-order correlation between them is .993.

A total of 234 of the Group I cases, or 54.9% of the 426, were located, and 142, or 33.3%, were interviewed. Of the Group II cases 73.7% were located and 56.5% interviewed.[1] Chi-square analyses of the

[1] A total of 191 families which were located failed to provide an interview because of our inability to actually make contact with the family, death of the child, movement of the family out of the state, or open refusal to cooperate with the study. The loss amounted to 29% of those located, or 19% of the total sample.

data indicate that a significantly higher proportion of the Group II cases were both located and interviewed. In view of the differences and considering the possibility that the investigator of the future may be interested only in treated cases, the pertinent data which follow are presented for both groups and for Group II alone.

Using the data of Figure 1 we can derive "regression equations" which will enable us to predict the most probable percentage of cases which can be located, and of cases which can be interviewed, as a function of time interval. These predictions can be used in planning future studies. The technique of derivation is known as the "method of least squares," and is the accepted approach.

The predicted percentages for year intervals from 1 to 15 based on the regression equations are listed in Tables 1 and 2. The estimated error in prediction is noted at the bottom of each tabular row. The interpretation of the error is that the actual percentage will be found within the limits of the predicted percentage plus or minus the error about 70% of the time, which is close enough.

To find the total percentage of cases which will be located or interviewed as a function of the longest time interval in the study, simply add all the tabular percents down to and including the longest time interval, and divide by that time interval. For example, a study using both treated and untreated cases whose longest interval is four years should expect to interview $(81+75+69+64)/4=70\%$ of the cases in

TABLE 1

Predicted percentages of cases which will be located as a function of time between close of treatment and follow-up

YEARS BETWEEN CLOSE AND FOLLOW-UP	PREDICTED PERCENTAGE OF SAMPLE OF TREATED AND UNTREATED CASES	PREDICTED PERCENTAGE OF SAMPLE OF TREATED CASES ONLY
1	94	93
2	89	89
3	84	84
4	79	80
5	74	76
6	70	72
7	65	68
8	60	64
9	55	59
10	51	55
11	46	51
12	41	47
13	36	43
14	31	38
15	27	34
ERROR	±3.5	±7

TABLE 2

Predicted percentages of cases which will be interviewed as a function of time between close of treatment and follow-up

YEARS BETWEEN CLOSE AND FOLLOW-UP	PREDICTED PERCENTAGE OF SAMPLE OF TREATED AND UNTREATED CASES	PREDICTED PERCENTAGE OF SAMPLE OF TREATED CASES ONLY
1	81	79
2	75	74
3	69	69
4	64	64
5	58	59
6	52	54
7	46	49
8	40	44
9	34	39
10	28	34
11	22	30
12	17	25
13	11	20
14	5	15
15	0	10
ERROR	±6	±4.5

the sample. Of course, this assumes that the number of cases sampled is the same at each time interval.

The predicted percentages of Tables 1 and 2 are technically applicable only to studies which are similar to the one from which the predictions were derived, i.e., to child guidance clinics in metropolitan areas, etc. It is not possible to estimate the errors which will be made in applying them to other kinds of follow-up investigations. It is likely, however, that they will hold up fairly well for any type of population varying mostly with the length of time, intensity and diversity of efforts at location.

If the predictions are modified appropriately to the efforts at location, they can probably be used with a relatively small error by the planner of any kind of follow-up study. At least they are better than nothing. It is recommended that future investigators publish accounts of locatability along the lines of the present report, so as to furnish further guides for various types of follow-up studies.

COLIN WHITE, M.B.
MARVIN REZNIKOFF, Ph.D
JOHN W. EWELL, M.D.

Usefulness of the Cornell medical index health questionnaire in a college health department

In recent years there has been an increase in the number of colleges where students, at the time of entrance, are given a medical screening by the college health department. An important element in this general survey of the student's health, including his mental health, is the medical history, and there is therefore great interest in any procedure which leads to the collection of better histories, especially if this can be done without using very much of the time of skilled personnel. It is just this advantage which has been claimed for the Cornell Medical Index Health Questionnaire (CMI) by its authors (1, 2, 3). The questionnaire is self-administered and consists of 195 yes-no questions which are worded simply and deal with signs and symptoms of present disease, past illnesses, family history, and patterns of mood and feelings. It is not feasible to reproduce the complete questionnaire, which is, in any case, widely known by now, but in the course of this article many of the individual questions will be referred to. The purpose of the present investigation was to examine the results obtained, particularly in relation to problems of mental health, when the CMI was used by a group of freshmen college students.

Mr. White is in the department of public health of Yale University School of Medicine, Dr. Reznikoff is director of the department of clinical psychology at the Institute of Living in Hartford, and Dr. Ewell is in the department of university health at Yale.

PROCEDURE

The subjects were 784 freshmen students each of whom answered the questionnaire as part of the routine of the initial physical

examination conducted by the department of university health. Each student was subsequently questioned in detail regarding five particular items about which he had given information on the CMI form. The period of time between the completion of the questionnaire and the interview was variable: in 156 cases it was less than one hour and in the remainder the interviews were delayed for from 16 to 28 weeks. The five inquiries pursued at the interview were presented as if they constituted a special investigation, and no reference was made to the CMI.

RESULTS AND DISCUSSION

Table I shows the frequency distribution of the number of positive replies recorded on each CMI. This variable is frequently used in psychiatric assessment, since it has been claimed that a score of 30 or more positive replies is good presumptive evidence of emotional instability. There were 24 students (3%) who showed this number of positive replies in the present series. In a more recent investigation Brodman *et al.* used 50 or more affirmative answers as a criterion for screening army pre-inductees (4), and according to this standard, two of the students in the present series would have been classed as emotionally disturbed.

To explore a possible relationship between emotional disturbance and the number of "yes" responses on the CMI, a follow-up was carried out, with the co-operation of the mental hygiene division of the department of university health. A record was compiled to show which students in the total group of 784 visited this division during the two years after the CMI questionnaires had been completed. In many cases the students went to the mental hygiene clinic of their own accord to take advantage of the consultation available there. In other instances the student was referred from another division of the department of university health, but in no case

TABLE I

Total number of positive replies for all students and for students who consulted the mental hygiene division

NUMBER OF POSITIVE REPLIES	TOTAL STUDENTS WITH STATED NUMBER OF POSITIVE REPLIES	STUDENTS WITH STATED NUMBER OF POSITIVE REPLIES WHO CONSULTED THE MENTAL HYGIENE DIVISION	
		No.	*Percent*
0- 4	273	12	4.4
5- 9	261	26	10
10–14	116	14	12
15–19	59	12	20
20–29	51	12	23
30 or more	24	10	42
Total	784	86	11.0

was the score obtained on the CMI a basis for referral to the division of mental hygiene; indeed, the score was not known by either the student or the doctor concerned. It is recognized that the emotional status of a student is inadequately gauged by merely noting whether he did or did not attend a mental hygiene clinic available to him, but we assume that such attendance may nevertheless be used as an indicator of emotional disturbance. The relationship between the total number of positive replies on the CMI and visits to the mental hygiene division is shown in Table I.

It is seen from this table that there is a positive correlation between the number of "yes" replies on the CMI and the percentage of consultations. Of the group of students with 30 or more positive replies on the CMI, some 42% visited the mental hygiene division; this percentage is higher than for any other group. The corresponding percentage for those with 15 to 29 positive answers is also higher than average. If the CMI is considered, among other things, as a device for detecting those who will visit the mental hygiene division, however, the group of students giving 30 or more positive answers provides only 10 of the 86 subjects sought. By taking all students with 15 or more positive replies one would include 34 of the 86 who attended the

TABLE II

Average number of positive replies per 1,000 subjects per question by section of CMI

SECTION OF CMI	AVERAGE NUMBER OF POSITIVE REPLIES PER 1,000 SUBJECTS PER QUESTION
A. Eyes and ears	92
B. Respiratory system	59
C. Cardiovascular system	31
D. Digestive tract	41
E. Musculoskeletal system	9
F. Skin	54
G. Nervous system	48
H. Genito-urinary system	21
I. Fatigability	38
J. Frequency of illness	2
K. Miscellaneous diseases	47
L. Habits	105
Mood and feeling patterns	
M. Inadequacy	51
N. Depression	12
O. Anxiety	55
P. Sensitivity	46
Q. Anger	50
R. Tension	31

mental hygiene division, but one would also include 100 of the 698 students who did not visit this division.

The questionnaire is divided into 18 sections and the relative importance of these might well vary somewhat from one population to another. In Table II is given the average number of "yes" responses per 1,000 subjects per question for each section of the form.

There are certain sections—E, J and N—in which the yield of positive replies is relatively low, and this is one indication that there are questions on the form which are not pertinent to this particular type of population. However, there is considerable variation within each section as to pertinency, and the questions have been considered individually with a view to removing those which have not been found useful for a student population. The results of this review of the suitability of specific questions for a college population are that the 24 questions listed below have been judged unsuitable, those in group A because the condition referred to is rare and those in group B because the answers obtained are difficult to interpret for this type of population. The percentage of students giving positive answers in the present study is indicated in brackets after the appropriate question.

GROUP A

Do you often feel a choking lump in your throat? (2)

Do you often have difficulty in breathing? (2)

Do you sometimes get out of breath just sitting still? (1)

Are your ankles often badly swollen? (less than 1)

Have you lost more than half your teeth? (less than 1)

Have you ever had serious liver or gall bladder trouble? (1)

Are your joints often painfully swollen? (0)

Do your muscles and joints constantly feel stiff? (less than 1)

Do you usually have severe pain in the arms or legs? (less than 1)

Are you crippled with severe rheumatism (arthritis)? (0)

Are you a bed wetter? (less than 1)

Are you constantly too tired or exhausted ever to eat? (0)

Are you always ill and unhappy? (0)

Are you constantly made miserable by poor health? (0)

Did a doctor ever say you have varicose veins (swollen veins) in your legs? (less than 1)

Do you often cry? (less than 1)

Does life look entirely hopeless? (1)

Do you often wish you were dead and away from it all? (1)

GROUP B

Do you find it impossible to take a regular rest period each day? (32)

Do you have to clear your throat frequently? (12)

Do you get out of breath long before anyone else? (6)

Do you usually eat sweets or other foods between meals? (33)

Do you always gulp your food in a hurry? (20)

Do you sweat a great deal even in cold weather? (14)

To enlist the fullest cooperation of the students it seems important to eliminate

all questions which they would not consider to be *bona fide* inquiries.

Number of "yes" responses on last page. The last (that is, the fourth) page of the CMI deals with patterns of mood and feeling, and a high number of "yes" responses on this page (more than three, according to the manual issued with the CMI) has been interpreted as suggesting psychological disturbance. The findings obtained in this investigation as to the number of "yes" responses on page 4 are listed in Table III.

There is a positive correlation between the number of "yes" responses on the last page and the number on the remaining three pages, as may be seen by comparing the first and the fourth columns of the table. However, the students who have more than three "yes" responses on the last page considerably outnumber those with more than 30 responses on the complete CMI; there is an obvious need to re-examine by further follow-up studies the dictum that those with more than three "yes" responses on the last page are possibly suffering from emotional disturbance. Such a follow-up has been carried out in the same way as that previously described for the correlation of visits to the mental hygiene section with total "yes" responses on the CMI. The results are shown in Table IV.

It is seen from this table that students with 4 to 6 positive replies on the last page did not include an unusually high percentage of men who consulted the mental hygiene division. If the criterion is made more rigorous, however, by taking only students with 7 or more replies, one finds that 27 subjects out of 76 visited the mental hygiene section. This criterion then compares favorably with that based on total number of replies, since a reference to Table I shows that the 75 students

TABLE III

Relationship of number of "yes" responses on last page and number of "yes" responses on first three pages

NUMBER OF "YES" RESPONSES ON LAST PAGE	NUMBER OF STUDENTS	PERCENT OF STUDENTS	AVERAGE NUMBER OF "YES" RESPONSES ON FIRST 3 PAGES	NUMBER OF STUDENTS WITH 30 OR MORE "YES" RESPONSES ON COMPLETE CMI
0	355	45.3	3.9	0
1– 3	272	34.7	6.6	0
4– 6	81	10.3	10.5	2
7– 9	38	4.8	11.5	3
10–12	19	2.4	13.3	4
More than 12	19	2.4	19.3	15
Total	784	99.9	–	–

TABLE IV

Number of positive replies on last page for all students and for students who consulted the mental hygiene division

NUMBER OF POSITIVE REPLIES	TOTAL STUDENTS WITH STATED NUMBER OF POSITIVE REPLIES	STUDENTS WITH STATED NUMBER OF POSITIVE REPLIES WHO CONSULTED THE MENTAL HYGIENE DIVISION	
		Number	*Percent*
0	355	20	6
1	127	14	11
2	102	9	9
3	43	7	16
4–6	81	9	11
7 or more	76	27	36
Total	784	86	11

with more than 20 positive replies included only 22 destined to visit the Mental Hygiene Clinic.

Answers to individual questions. A list is given in Table V of the percentage of positive replies to certain of the individual items on the questionnaire. The figures must be regarded with reservation since they deal with reported conditions rather than objectively evaluated conditions, but they give an indication of how a questionnaire could be made a starting point for the collection of normative data on the particular population under study. A short experience with this or a similar form would give general orientation regarding the frequency of a particular condition and therefore provide basic information needed for the planning of a detailed study in this population. The CMI alone is not a suitable instrument for obtaining definitive normative data, and, of course, it was not designed for this purpose.

Some more detailed study of the answers to individual questions is also feasible; for example, a point of interest is the relationship between the total number of "yes" responses and the replies to particular questions. Since there is evidence that those who give numerous positive responses on the CMI may differ from their fellows in emotional stability, it is of value to examine the replies to certain questions in the light of the total positive responses given by the subject. For this purpose the students were classified into three groups: A, those who gave less than 10 positive replies; B, those with 10 to 19; and C, those with more than 19. The essential information brought to light can be described by comparing groups A and C. For each group the whole 195 questions were ranked in order, rank 1 being given to the question attracting the largest number of "yes" responses, and so on. Certain questions were ranked much higher by group A students than by Group C students and vice versa. A list has been made of those questions

which differed in rank by 20 or more places when group A was compared with group C. Take, for example, the question: "Did you ever have a serious injury?" This was ranked 12 by group A and 63 by group C, a decrease in rank of 51. In all instances the rank from group B was intermediate. Questions were ignored if they did not receive at least 10 positive answers in either group A or group C, this restriction being necessary to remove items on which no substantial information was available even though the rank seemed to change considerably.

There were 29 questions which by these standards were ranked much higher in group C than in group A, so that these may be considered the questions that the group of students with a high number of positive answers were especially likely to answer affirmatively. Of the 29, there were 20 from the last page, a point which once again emphasizes the relationship between a high total number of positive responses and a high number on the last page. In particular, more than half of the questions dealing with anxiety, sensitivity and anger were given a high ranking by group C. Conspicuous exceptions as far as the last page of the CMI is concerned were the questions on depression and tension, only one of which was ranked relatively high by group C. A possible explanation of this is the age group of the subjects concerned,

TABLE V

Frequency with which various conditions were reported

CONDITION	PERCENTAGE OF STUDENTS ANSWERING "YES"
Glasses needed for reading	26
Glasses needed for distant vision	34
Difficulty in hearing	1
Epistaxis	16
Hay fever	23
Asthma	4
Hemoptysis	2
Hemorrhoids	3
Bed wetting (between ages of 8 and 14)	6
Hernia	5
Otitis media	10
Scarlet fever	9
Rheumatic fever	5
Serious operation	11
Serious injury	11
Family history of heart disease	7
Family history of arthritis	3
Family history of epilepsy	1
Family history of nervous breakdown	8
Family history of treatment in mental hospital	4

since emotional troubles in young people are more likely, on the whole, to be expressed by anxiety, sensitivity and anger than by depression. These findings indicate that even the subjects with many positive replies followed a pattern with regard to the type of question to which they gave a high ranking. This same point is brought out by consideration of the 9 questions on the first three pages that attracted high ranking from group C, namely:

Do your eyes continually blink or water?
Do you suffer from a constantly running nose?
Do you frequently suffer from heavy chest colds?
Do you sometimes have severe soaking sweats at night?
Does your heart often race like mad?
Do you get out of breath long before anyone else?
Do you usually feel bloated after eating?
Do you often get spells of complete exhaustion or fatigue?
Does working tire you out completely?

Many of these could well be expected to reveal more about emotional difficulties than about organic disease, and it is therefore consistent with previous findings that they should be ranked high by students with a high total of "yes" responses.

The 29 questions referred to above were not only given a higher rank by group C but also attracted a higher percentage of positive replies from this group than from group A. This naturally follows since group A gave relatively few positive answers.

There is a second group of 17 questions which were given a lower rank by group C than by group A. Only two of these, one referring to a family history of nervous breakdown and the other to a family history of treatment in a mental hospital, were questions from the last page. Seven of the 15 questions were from a single section—K—on miscellaneous diseases. In this section the questions mostly deal with specific, defined diseases or symptoms. The remaining 8 questions in the list of 15 given higher rank by group A are:

Are your eyes often red or inflamed?
Has a doctor ever said you had a hernia (rupture)?
Do you suffer from asthma?
Does heart trouble run in your family?
Were you a bed wetter between the ages of 8 and 14?
Do you bite your nails badly?
Has a doctor ever said your blood pressure was too high?
Have you at times had a twitching of the face, head or shoulders?

The first question above, in addition to obtaining a higher rank in group A than in group C, had a slightly higher percentage of positive answers in group A than in group C; and the second question had almost as high a percentage of positive answers in A as in C. In all other cases the preference shown by group A for answering these questions positively was only a relative preference in that although the rank given was higher the percentage answering "yes" was actually lower. For example, the question about serious injuries, as mentioned above, had a higher rank in group A than in group C but was answered positively by only 9% of group A as against 18% of group C.

RELIABILITY OF INFORMATION OBTAINED

A central problem in this investigation was a consideration of the quality of the information that can be obtained by means

of a questionnaire such as that employed. The reports in the literature on the use of the CMI are almost all highly favorable to it. However, Glasser and Whittow (5) warned of possible difficulties in obtaining information from this technique, but did not actually report on specific use of the CMI. There is, of course, a great deal of general information regarding the biases found in the answers to questionnaires, but each case must be considered on its merits since important factors such as the degree of motivation might vary considerably from one example to another. In the present work two types of checks have been applied to the answers given on the questionnaires.

Check against background information. Using background knowledge of the prevalence and relationships of various diseases, one may apply certain approximate checks on the trustworthiness of the data obtained. For example, it is well known that rheumatic fever is a sequel to streptococcal infection, and according to one authority (6) it follows clinical attacks of such infections in about 3% of the cases. On the CMI, information is requested about attacks of otitis media, scarlet fever and rheumatic fever. The answers are classified in Table VI. There were reports of rheumatic involvement in about 6% of those who had had scarlet fever or otitis media and in about 5% of the remainder. These percentages are not significantly different. They are both rather high, possibly due to the fact that the vague entity "growing pains" was linked with rheumatic fever, but the important finding is that rheumatic fever was not significantly more common in those with major streptococcal infection than in the remainder. This particular check of the details suppplied by the CMI is an exacting test, in view of the small numbers involved, but the failure to find a correlation which is probably present in the population is a warning against hoping for too much from data collected solely by this method.

Another curious result was obtained in response to two simple questions regarding the need for glasses. Seventeen percent of the students stated that they needed spectacles for both reading and distant vision. An additional 16% reported that they used spectacles for distant vision only and a further 8% that they used them for reading only. The number using spectacles

TABLE VI

Relationship between history of rheumatic fever and history of either otitis media or scarlet fever

	HISTORY OF EITHER OTITIS MEDIA OR SCARLET FEVER OR BOTH	NO HISTORY OF OTITIS MEDIA OR SCARLET FEVER	TOTAL
History of rheumatic fever	9	32	41
No history of rheumatic fever	134	609	743
Total	143	641	784

TABLE VII

Frequency distribution of number of bowel movements in a particular week

NUMBER OF BOWEL MOVEMENTS	STUDENTS WITH STATED NUMBER OF BOWEL MOVEMENTS	
	Number	*Percent*
0	1	0
1	0	0
2	0	0
3	7	1
4	9	1
5	35	4
6	46	6
7	463	59
More than 7	223	29
Total	784	100

for distant vision only is surprisingly high and suggests some misinterpretation of the question.

Specific study by means of interview. Five of the replies given on the CMI were selected for detailed study. The questions so selected were the following, the number in brackets being the number of students, out of the total 784, who answered "yes" to the question when filling in the CMI:

(a) Are you frequently ill? (4)
(b) Do you suffer badly from frequent severe headaches? (22)
(c) Do you suffer from frequent loose bowel movements? (8)
(d) Does heart trouble run in your family? (51)
(e) Did you ever have a fit or convulsion (epilepsy)? (5)

The fact that few students gave positive answers to (a) or (e) on the CMI makes it unprofitable to analyze the follow-up results for these questions. There were also few positive answers to (c) but the information obtained on frequency of bowel movements is presented as normative data for this group.

There were 766 students who stated on the CMI that they did not suffer from frequent severe headaches. On interview 720 of these reported that they had not had a headache in the previous week and that this was their typical experience. The remaining 46 had had headaches in the recent past: 38 had had 1 to 3 in the previous week and 2 had had 6 or more. Of the 22 students who answered "yes" to the question on the CMI regarding frequent severe headaches, 17 had not had a headache in the week prior to interview and 10 of these did not report any earlier experiences that would support their statement on the CMI.

A review of these results shows relatively few discrepancies between what was written on the CMI and what was reported at detailed interview. Perhaps this is owing in part to the low incidence of frequent severe headaches in this sort of population. Such discrepancies as were revealed occurred mainly in the group who claimed on the CMI that they were suffering from headaches.

A frequency distribution of the number of bowel movements during the week prior to interview is shown in Table VII, and illustrates the possibility of obtaining certain types of normative data by this method.

Of the 8 students who claimed on the CMI that they suffered from frequent loose bowel movements, 7 reported on interview that they had 7 or more bowel movements a week. From Table VII it is seen that 463 out of 784 students (59%) made a similar report.

There were 51 students who stated on the CMI that heart disease ran in the family. At interview relatively few of these could produce supporting details that distinguished them sharply from many who had not made the claim, since only 24 of these students (47%) had 2 or more members of the family affected with heart disease. In the group who gave a negative answer on the CMI there were 17% who had two or more relatives affected. Specific inquiry was made regarding parents, aunts, uncles, brothers, sisters and grandparents. Approximately half of the students could not name a single relative affected by heart disease—a proportion which is perhaps kept high by reason of the age of the respondents and the incomplete knowledge of the details of the medical histories of those outside the immediate family circle.

CONCLUSIONS

The CMI may be recommended for use in a college health department, but with some reservations. It has the advantages of being simple, convenient to use and acceptable to the students, and since it is fairly exhaustive it may reveal important details that would be overlooked except in a lengthy history. It has particular value in drawing attention at an early stage to students who are likely to seek counseling regarding mental health. On the other hand, each subject must interpret the questions without guidance, and there are indications that varying interpretations are given to such apparently simple queries as to whether heart disease runs in the family. For this reason even *bona fide* answers given on the form may be inaccurate, so that the index should be thought of as a screening device rather than a definitive history. In spite of the attempt to make the CMI universally applicable, a number of irrelevant and therefore distracting questions become obvious when the questionnaire is used on a special group such as a college population. For this population of relatively healthy people the index, although useful, has not had the striking success claimed for other groups (1, 2, 3).

SUMMARY

1. A freshman class of 784 students completed a CMI health questionnaire on attending a department of university health for an initial examination.

2. The distribution of the total number of "yes" responses has been recorded. There were 24 students (3%) with 30 or more. Those students with a high number of total "yes" responses attended the mental hygiene section in relatively larger numbers than other students. As an alternative to the total number of "yes" responses, one may obtain an equally sensitive and somewhat more specific criterion of the probability of attending the mental

hygiene section by counting the number of "yes" responses on the last page. Of the 76 students with 7 or more positive answers on the last page, 27 attended the mental hygiene section.

3. Although the CMI has been recommended for use in colleges, there are some sections with many questions which are not relevant to this type of population. A list of such questions has been compiled.

4. A study has been made of the replies to individual questions. The 195 questions have been ranked in order according to the number of positive replies given by students with many positive replies (more than 19), by students with an intermediate number (10 to 19) and by students with few (less than 10). The rank of the individual question varied with the group of students, and these variations are discussed.

5. The answers given by the students have been checked for reliability by (a) relating the replies to background statistical information about the type of population sampled, and (b) interviewing each student and obtaining details about 5 of the items included on the CMI. These interviews were conducted as if they constituted an inquiry quite unrelated to the filling-in of the CMI.

ACKNOWLEDGMENTS

We are indebted to James S. Davie for help in the follow-up of students visiting the mental hygiene division of the department of university health, and to Mrs. C. Clay for assistance with the interviewing.

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WILLIAM G. HOLLISTER, M.D., M.P.H.

Five years' experience with lay discussion leaders in mental health education

In an effort to explore methods of obtaining wider population coverage in mental health education, the mental hygiene division of the Alabama State Department of Public Health [1] joined forces in 1950 with a group of agencies and associations in Birmingham [2] to develop and study a program of parenthood education using lay discussion leaders. All the groups involved were interested in strengthening the ability of parents to guide the healthy development of their children's personalities and behavior through "common-sense, home management" methods. They also wanted to know "How is it possible to reach large numbers of parents with simple, practical learning experiences on child behavior guidance?" and "What kind of behavior guidance information do parents need?" For instance, these community leaders were asking "Is it best to reach a few people with our limited supply of professional personnel or is it better to develop wider coverage with simple materials using selected and trained lay leadership?"

To answer some of these questions, the local Council of Parents and Teachers, the

Dr. Hollister is consultant on mental health in education for the community services branch of the National Institute of Mental Health.

[1] Directed successively by Dr. Jack Jarvis, Dr. William H. Knapp, Miss Mary Belle Roberts and Dr. John M. McKee.

[2] The City Council of Parents and Teachers (Mrs. Eugenia Akin, parent education chairman), the Birmingham-Jefferson County Mental Health and Social Hygiene Association (Mrs. Vera H. Bruhn, director), the Birmingham-Jefferson County Health Department (Dr. George Dennison, director, including the mental hygiene clinic and the division of health education under John K. Williams) and the city school guidance department (Dr. I. R. Obenchain).

public health department, the guidance division of the city school system, the mental health clinic and other local groups pooled their resources in a cooperative project. Under the guidance of consultants provided by the state mental hygiene division, this program and its study of lay leadership and parent discussion groups was initiated under the title of "Education for Responsible Parenthood" or "Personality Building in the Home." Over the last five years the groups concerned have sought: (1) to give a clear picture of parents' felt needs for help in guiding children's behavior; (2) to delineate by field experience the appropriate role and use of a trained lay discussion leader; (3) to define his training and supervision and (4) to evaluate the impact on parents of discussion groups led by laymen. This project expanded to such proportions that it in part precipitated the organization of the Birmingham-Jefferson County Social Hygiene and Mental Health Association, which now assumes the major responsibility of conducting this program. This paper represents a progress report and a formulation of the learnings to date.

OBJECTIVES

The objectives for this program have undergone considerable change as new experience and a better knowledge of parents' needs accumulated. At present this mental health education program seeks:

- To help parents feel more secure and confident in their ability to guide the behavior and personality development of their own children.
- To reduce the anxiety and interpersonal conflicts in families that arise out of lack of knowledge about children's growth and needs.

Based on the experience to date, those involved in the program have become convinced that parents' need for security and confidence is greater than their need for information. This conviction has directed the choice of educational methods utilized toward those designed to create security, safety and stimulation toward study, rather than those that concentrate mainly on intellectual learnings.

THE METHOD

To meet these objectives, this program attempts to prepare a lay leader who can help a local neighborhood, school or church group of parents gather in small groups:

- To build their own agenda of child-care problems.
- To engage in an interesting variety of group problem-solving and discussion methods.[3]
- To become stimulated to use resources and compare experiences.
- To develop by parent self-decision a variety of possible ways to manage these problems in the home.

The basic method was borrowed from the original Education for Responsible Parenthood program of Mississippi, which has previously been reported (1, 2).

The focus is on parent self-decision and the parents' freedom to create their own

[3] The basic method of this program was borrowed from the original Education for Responsible Parenthood program which was first developed in Mississippi in 1944 (1) and then spread to North Carolina, South Carolina, Tennessee, Arkansas and Georgia. In 1950 the state mental health programs of Alabama, Mississippi and Georgia financed a field survey of these programs and the preparation of a discussion leaders' manual (2), which contains the field-tested techniques that lay discussion leaders have used with success. The manual is a compendium of alternative group methods and readings.

pattern of home management. The emphasis is on the "normal" everyday problems of child care, not on the clinical problems that belong in the hands of specialists.

A group numbers from 6 to 30 parents, who gather around a dining-room table at a home or in a room at a church or a school. They usually meet three or four times for two or three hours, and it is not unusual for them to decide to continue for six to eight sessions. The discussion leader's role (which is more completely described in following sections) is simply to expedite the flow of discussion, to create a safe climate for complete group participation and to mobilize resources as needed. At no time does the leader become a resource person on the content of the discussion. He suggests to the members of the group the methods and approaches they might use to study their problems. He helps to obtain films, pamphlets, books and visiting resource people as needed. No "expert" is brought in until (a) the group itself has defined and discussed some questions on which they want special help, and (b) the group's sense of cohesion and its ability to think for itself has matured to the point that it will not use the resource person in abject dependency.

By eliminating the use of lectures that present ideal standards of conduct, an attempt is made to avoid making parents feel inadequate, anxious or guilty, or believe that "the material is too general to fit my home." In our experience, a semi-structured pattern of group activity under a non-status leader seems to provide ample areas of freedom for each parent to give and to find "something for himself."

Some of the methods developed and learnings that have emerged over the last five years are presented briefly in the sections that follow.

DISCUSSION LEADER TRAINING COURSE

The discussion leader training course has been progressively refined by experience. It now lasts for three days (16 to 18 contact hours) and is staffed with personnel trained in mental health, education and public health. The participants are drawn from local parent-teacher associations, churches, neighborhood groups or schools. They are selected by the training course staff on the basis of interest, readiness, willingness to perform as discussion leaders and willingness to be supervised in the field. Recruits are now drawn mainly from outstanding participants in previous study groups. We have noted that as the program has become better known and accepted in the community those who present themselves for training have had progressively more experience in leadership roles and more formal education. In 1950 the first 30 trainees had to be recruited. In 1955 the 11 courses that provided training for the 392 parents and teachers were oversubscribed.

Basically the course consists of three experiences for the trainee:

1. An experience for self

This is the experience of actually going through a discussion group (10 hours) during the course in order to get the "feel," observe the procedure and meet some of the trainees' own informational needs.

2. Background information sessions

These consist of periods devoted to giving the discussion leader an outline orientation in the emotional, social and physical growth of the child.

3. Skill practice sessions

During these periods the skills of leadership and group participation are demon-

strated, then actually practiced. In addition, the mechanics of setting up the discussion groups, planning, mobilizing resources and the handling of occasional difficult situations are discussed.

Experience with the task of training lay discussion leaders has revealed the high importance of an "experience for self." Discussion leader training not only involves an opportunity to acquire new knowledge and to learn new skills, but also involves the task of getting emotionally ready. When the prospective discussion leader has had a meaningful experience that was personally helpful, when he or she has experienced the "feel" of a cohesive, mutually supportive group, then a real personal motivation to help others seems to develop. Having caught a fuller meaning for himself, the trainee appears more ready to turn toward helping others discover this same experience for themselves.

The background information sessions are given not to help the discussion leader become a pseudo-expert but to provide an intellectual foundation for creating better discussion, and an overview lending perspective on the resources needed to help the group.

The skill practice sessions are for units of five or six trainees, with a staff member, who one by one take turns being leader while the others act as participants. They practice the verbal skills involved in initiating the various types of group activities. They are taught and practice the skills of leading the following kinds of activities a group may need in order to carry out a discussion of its self-selected topics:

Agenda-building and opening skills

Welcoming talk, defining the discussion leader's role, explaining the group discussion plan, getting the people introduced, doing an interest survey, helping the participants to classify and group their interests, set priorities, and set up a schedule.

Study-discussion skills

Use of buzz groups and work groups, report sessions, general discussions, trait-cause discussions, application discussions, simple role-playing (leader-group, leader-member, member-member), summarizing and recording.

Resource-introducing skills

Using panels (symposium, discussion, spontaneous and interview types), round-robin reading, newspaper or magazine article "clipping clinics," abstracting main ideas from pamphlets, group chart study, film use technique ("feeling with" and "helping person" techniques) (6). Time is also spent learning how to help a group prepare for and wisely use a resource person.

Limit-setting skills

Special attention is given to preparing the discussion leader to help the group recognize its limitations. One of the most successful devices in gracefully keeping a ceiling on activities so that the group does not go beyond its capacities is an "unmet needs list." A large piece of paper is hung on the wall each session. When anyone introduces a clinical problem, the leader asks the group whether they feel they can discuss this or whether skilled help may be necessary. If it is beyond the group's capacity to handle, the item is then placed on the unmet needs list with the understanding that the questioner and the discussion leader will work together after the group meeting to find an appropriate resource. Questions on which discussion has

failed or reached an impasse also can be placed on the list. The list can be mailed to a future prospective visiting resource person so that his contribution may be made directly on some of the points on which the group desires help. Through use of this unmet needs list and continual offers to try to help an individual find aid on a special problem outside the group ,the leader is more able to keep the discussion focused on the everyday problems of living, on the front-line mental health job of guiding growing personalities in the home.

FIELD SUPPORT OF LAY DISCUSSION LEADERS

One of the unique developments of the Birmingham program of Education for Responsible Parenthood has been the origination of an organized field support program for discussion leaders who have been trained. In previous experiences in Mississippi only about 50% of those trained actually performed. The institution of an organized field support program by the sponsoring agency has helped over 90% of those trained to perform. With field support and frequent training courses, it is now possible to maintain a corps of 125 to 150 discussion leaders active in the community. Such trainees serve an average of two or three groups a year and remain active an average of one and a half years. For several years over 5,000 parents annually have attended the various discussion groups.

On the basis of field experiences in Georgia and Tennessee and locally in Birmingham, a complete field support program should include the following:

1. A materials resource center

A library of pamphlets, books, film strips, films, recordings and plays, open daily for the discussion leaders' personal study and for their use during discussion groups.

2. A special problem resource center

The local mental health association or a child guidance clinic can give priority to phone calls and letters from trained discussion leaders and attempt to support them with interpretations, suggestions and referral to literature resources. The support of a clinically trained mental health consultant is desirable.

3. Materials resource lists

Each discussion leader can be given lists of materials available from each local and state agency that can be easily obtained for the use of his group.

4. Resource person lists

Each leader can be given a list giving the name, profession, area of competency and travel costs, if any, of persons who know the group discussion process well enough to act as resource people without interfering with the group experience.

5. Field consultant

An experienced discussion leader who knows each trained lay leader personally can be made available. By telephone, this field consultant promotes the use of the discussion leader by conferring with the officers of the club or organization that sponsors the discussion leader. It seems much easier for a third person to promote the use of the discussion leader than for the discussion leader to push himself. This "guardian angel" also phones to talk over plans with the discussion leader the week before he starts a new group, often attends the first meeting as moral support and gives continued consultation, as needed, on the mechanics, problem situations and the

mobilization of resources. In Birmingham the Social Hygiene and Mental Health Association now provides a consultant to meet this need.

6. Discussion leader reunions

Regular monthly meetings of discussion leaders to discuss the problems they are facing are conducted by the field consultant. Presentation of new materials, demonstrations and postgraduate education of the discussion leaders takes place at these meetings.

7. Pairing device

Discussion leaders planning to operate in contiguous neighborhoods are encouraged to team up. One agrees to help the other with her group in return for the same help in her neighborhood. This plan appears to encourage newly-trained leaders and to provide them with additional support.

8. Sponsoring support group

Each discussion leader trained is urged to gather a sponsoring and supporting committee around him or her. He or she is encouraged to gather a group of friends around the dining-room table in his own home about a week after the training course and to practice going through the steps of a miniature discussion group. With this method the trainee gets a chance to practice and to mobilize a group of supporters who can attend the first discussion group, who know what the discussion leader is trying to do and can be supportive, fill in silences and even promote attendance.

9. An annual summer camp

In the Birmingham program, a summer week-end retreat is held annually for discussion leaders and their families. In addition to general recreation and information sessions, there are separate advanced, beginners' and children's programs at the camp that have helped to provide growth and experience for every member of the family of the discussion leader. Participants report that these three days of freedom from responsibility for their children, during which to share with their husbands the study of some problems of family life, have been a personally meaningful experience. This experience also has helped to motivate several husbands to become discussion leaders too.

These simple and logical devices appear to be essential in helping lay discussion leaders perform and in enabling them to improve the quality of the experiences that they can help their groups build.

EVALUATION OF THE FIELD PERFORMANCE

An evaluation of this program as it is operated in Birmingham is continuously being made on three levels: one, from opinions of the participants; two, from opinions of trained observers from the fields of psychiatry, psychology, social work and education; three, by a program of objective research. This objective research program is both long and complex, involving problems of criteria development as to what constitutes good parenthood and good mental hygiene as determined by each demographic group in the community. The "critical incidence" and "forced choice" techniques are being used in this criteria development and validation. It will take some time to complete this study (5).

As one attempt to answer "What does a group experience with one of these trained lay discussion leaders accomplish?" we have personally interviewed a sample of 47 par-

ticipants and a second group of 12 mental health specialists and 5 educators who have observed one or more of the groups. These interviews consisted only of asking and clarifying the answers to two questions:
1. What values did you find in this experience for yourself (or for the participants)?
2. What were the strengths and what were the weaknesses of the method, content or leadership of the program?

THE PARTICIPANTS' EVALUATION

The participant sample consisted of 40 women and 7 men who were interviewed during one of the 1954, 1955 or 1956 summer parenthood education camps for lay leaders and parents. The sample is subject to the bias of all the selection factors that motivated these individuals to attend this camp. They most likely represent a more highly motivated and favorably impressed sample than the general population of participants.

Although the interviews were spread over three years' time, there is a remarkable consistency year by year in the values, strengths and weaknesses identified, a finding that is of significance in itself. The most commonly stated replies were:

1. Values found in the experience

- A sense of personal growth

"We've found new ways of relating in our family."

"I've grown up a little since then."

- New sensitivity

"I had my eyes opened to how children (or parents) feel . . . I sense this more at home now."

- Breaking the feeling of isolation or being different

"I feel less different." (This was the most common reply.)

"I found others have the same problems, too."

"I found some troubles are normal troubles."

- Helpful information

"I got a better understanding of behavior."

"Learning about the stages of growth (or normal problems) was most helpful."

"I got some new light on one of my problems."

- Stimulated thinking and reading

"It was food for thought."

"I've stopped many times to think about it."

"I've read more since."

- Stimulated relationships

"It led to some good talks with my husband."

"I felt freer to go talk with my child's teacher."

- Provided reassurance and confidence in self

"I feel more sure of myself now."

"If other mothers can do it (child care) I can."

"It's wonderful to know you can relax and be yourself and raise your children your own way."

- Freedom to express feelings

"There was a wonderful feeling of caring for children in the group—it made me want to love mine all the more."

"This is the first group in which I felt accepted."

- A sense of resources

"Now I feel I've got friends to talk with about my problems."

"I've found some places to get help." (This referred to agencies).

2. Strengths of the program (content, method or leadership)

The most frequently mentioned strength of the group experience included: "It was so friendly. We were made comfortable with one another. Somehow it was easy to talk, and the informality or discussion brought us closer to our child's teacher or to our neighbors." Other comments included: "It was not all cut and dried," "We got to talk about what we wanted to talk about," "The leader made everything group-centered" and "We all had a chance." Typically one heard: "I like discussing—a small group is enjoyable and safe."

3. Weaknesses of the program

Criticism about results centered around "There was no expert there to guide us," "I didn't get my main problem solved" (usually meant some clinical condition), "Not enough time to discuss," "One of the members talked too much," and "No one's attitudes got changed."

Weaknesses identified about the mechanics included irritation with poor continuity of member attendance ("They miss, then lose interest"), difficulty of finding a common time ("You don't reach the people who need this") and complaints that the discussion method allowed a few to monopolize the group.

Apparently most of the sample liked their leadership services, but a few indicated that their particular leader talked too much, tried to dominate, didn't involve the group or tried "to answer the questions herself." Each of these people asked if leaders couldn't be picked and screened more carefully. Another interesting challenge was continuously voiced in a request to "do something about those people who come to these groups just for sociability" or about those who come to voice a grievance against the school.

Other significant weaknesses are highlighted in the postgraduate reunions of the discussion leaders when these leaders bid for more help in the management of "group dominators" and "the setting up of a code of confidentiality" so that things shared don't become gossip. Apparently one of the most difficult and continuous tasks of the discussion leader is to deal with individuals seeking to use the group as a clinical resource. To meet these individual needs, it is often necessary to defer the discussion of a clinical problem to a personal conference with the leader after the meeting, when referral to a clinical resource can be effected. Sometimes it is possible to defer discussion of a clinical problem by listing it on the unmet needs list (see above) for eventual handling by the trained visiting resource person. It may take frequent emphasis on "We're looking at the usual problems of child care" or "We're looking at home management" to keep the group focused on its area of competence. Discussion leaders report that some who enter the group to seek clinical help or answers from experts do drop out.

VALUES TO THE COMMUNITY

As an added dividend, the replies received from the participants revealed values best classed as values to the community. The local PTA leadership reported a resurgence of interest in their work. "We're reaching people we never reached before" and "It's really stimulating teacher and parent conferences and teamwork." Teachers reported that "more parents were coming in to talk about their children," "parents were friendlier" and that their participating with parents in discussion groups made their "jobs more rewarding." As a by-product

of these values to the community, increased numbers of teachers have enrolled and completed training as discussion leaders and now meet regularly with the parents of their classes. Some teachers and principals now feel that the increase in school study groups jointly led by trained parent and teacher discussion leaders had enhanced and vitalized the total Parent-Teacher Association and school program. Another by-product has been changes in the type of church and PTA meetings as trained discussion leaders begin to apply their new group participation skills to larger groups. The increased personal and social effectiveness of the trained discussion leaders has resulted in many of them succeeding to the PTA presidency and other officerships. Indirectly, the program has discovered and helped develop new community leadership.

PROFESSIONAL OBSERVERS' EVALUATION

At various times, one or more neighborhood study groups have been attended and observed by one of a group of 3 psychiatrists, 4 clinical psychologists, 5 psychiatric social workers and 5 educators. The values, strengths and weaknesses identified by these observers in many ways parallel those of the participants, but were frequently presented in a more sophisticated language. In addition to those values, weaknesses and criticisms listed above, the following observations of the professional observers are presented:

Values

In listing the values they feel participants derived from the group discussions, the professional people commonly cited the following: finding a sense of security and acceptance, gaining reassurance, developing a long-range perspective on problems, acquiring new information, and discovering new ideas and feelings in the freedom of a safe, comfortable small group. They noted that participants used the group to meet independence strivings, to gratify dependent needs, and to work out family conflicts symbolically in the safety of the roles in the group. Some felt the group helped to meet certain needs for recognition and support or needs to act out substitute satisfactions.

Strengths

In response to questions on the strengths of the program content, method and leadership, the majority of professional observers were impressed by the favorable learning climate of the discussion groups they attended. The educators felt that the program's accent on group-built agenda and group problem-solving, the use of resource persons (usually reserved for the last meeting), as well as the emphasis on doing, demonstrating, feeling, working out "your own answers" and "putting things in the same words you would use with your child" contributed greatly to the learning impact. One educator stated: "Apparently lectures and the printed word communicate poorly to some parents. Possibly the methods used here more nearly meet the learning patterns of the doer, feeler and relator kinds of learners." He felt that these kinds of learners might be more attracted to these sessions, thus bringing in a skewed sample of learners into these discussion groups. As an example of emotional learning, one father said, "What did I get? Somehow I gradually caught the feel of getting along with my children." A mother said, "Once I had practiced answering children's questions in the groups, I found I could really

do it more gracefully and with the right feeling at home."

The list of mental health strengths identified by the professional observers practically duplicates the values listed above by the participants. In addition, several mentioned their growing belief, as they listened to mothers talk in these groups, that much of their anxiety is unnecessary and rises out of ignorance of normal variations of child growth and behavior. Without overlooking the possibility that some anxieties expressed are symbolic of deeper problems, most felt that the program, to some degree, diminished and prevented anxiety by its simple anticipatory guidance and information as well as mutual emotional support in the group. (For example, "It's just a stage of growth and you will live through it.") The clinicians noted how often participants found release from guilt about their failure to achieve book-learned or lecture-inculcated high standards of behavior in their children. When they found that others miss the mark too and that "you don't have to be perfect," there was real relief expressed. One psychiatrist felt this was a form of reassurance that came, at its best, from other parents in free discussion.

Weaknesses

Some observers felt that the use of films, pamphlets and a resource person at the terminal meeting did not always prevent poor information and inaccurate solutions. Others reported that stereotypes, pat solutions and punitive attitudes sometimes get reinforced, some of which may lead to a degree of socially approved adjustment but not always lead to the best individual development. Many of the trained observers expressed the belief that the personal equation of each leader's personality causes the quality of a group's experiences to vary considerably and urged careful screening of leaders. Some noted anxious leaders over-controlling a group and occasionally losing their role by expressing personal opinions or mobilizing toward conformity pressures.

One group of observers felt the content was too de-emphasized. They also felt that lay leaders were too rigid and structured in the process of leadership and they deplored the lack of more complete group freedom in self-direction. To a degree such criticism is correct, for these lay leaders are trained to develop some structure in collaboration with the group. Our experience has led us to the conclusion that lay leaders feel more comfortable and function better in semi-structured situations where they have some control over the choice of methods but where the group has freedom over the choice of topics. These "negatives" present many challenges in program development, some of which are probably the standard risks to be encountered in the use of lay leadership.

One of the most interesting professional criticisms of the value of discussions led by laymen has been the charge that they merely "pool the collective ignorance of the group." Our observations tend to confirm Norman Maier's (4) experimental findings that "ignorance pooling" is avoided and sound practical solutions are discovered more frequently by the group when the leader actively protects the right of minorities and provides an opportunity for all to participate. When discussion is free and the minority voice is given a chance, our observers have noticed that the discussion moves beyond "ignorance pooling" into more critical comparisons and tests of the ideas submitted. Noting this, we have encouraged discussion leaders to establish the

idea that "there are many answers to these human relations or family living problems" and to poll the whole group frequently. Then the ideas submitted can be tested to see if they "square with the reality of using them in your home." By this means, an individual has a better opportunity to choose a solution or interpretation that fits herself, her home and her family or even to reject all the choices.

In general, these observations and follow-up contacts suggest that the program has, for some of its participants, stimulated them to further study and reading, diminished some of their anxiety over child behavior and individual differences, developed a sense of more acceptance, recognition and/or confidence in the parental role, and provided new information and new resources.

The observers also conclude that the program is subject to limitations in its service to parents in that (1) it does not meet the occasional need for clinical service that parents present, and (2) it is difficult, with volunteer lay leadership, to control and maintain the quality of group education. In general, our observers have agreed that this program should not and cannot be expected to meet the wide range of parental need, but that its advantages outweigh its disadvantages. From the above subjective personal reports and comments of trained observers, there is still insufficient evidence on whether changes occurred in basic attitudes or performance. The development of a scientific sample and criteria and the execution of an objective study are in process now (5). The descriptive evaluations reported above have been encouraging enough to conclude that the public and professional acceptance of the program is sufficient to warrant its continuation, further exploration and study.

SUMMARY

As a result of the five years' experience and the valuable insights given us by our participants and professional observers, our understandings, skills and goals have been redefined. At present the lay leaders tactical goals have become the creation of a small group discussion experience that is characterized by:

- A group-built agenda (some measure of group self-direction.
- Group problem-solving (participation in self-decision).
- Free discussion by all (minorities protected to prevent ignorance pooling) (4).
- Social safety to express feelings.
- Opportunity to relate to others and thus understand them better.
- A chance to explore, test and compare ideas as to whether they fit social and emotional reality.
- Opportunity to listen, perceive and become sensitive to others.
- A chance, in the anonymity of the group, to see and test oneself, and perhaps to understand oneself better.

This kind of group experience moves beyond the usual group dependency upon the expert to opportunties for self-discovery and personally working through solutions. In such a group, information is sought as needed instead of introduced by experts. The learning experience is more learner-directed, for learning comes through participation, self-decision and shared experiences as well as through contact with new information. It is felt that this kind of social experience in relating and learning can build confidence and self-reliance. It

emphasizes a basic belief in the average parent's capacity to solve his own problems and to use resources wisely.

As we see it, the continued task of such mental health education programs is to refine the selection, training and performance of discussion leaders and to reach a greater number of homes with the positive mental health potentials of the learner-centered type of discussion group experience.

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NORMAN M. CHANSKY

How students see their teacher

As a teacher, the writer is curious about the attitudes that students hold toward him. Assessing students' attitudes permits him to plan his teaching so that the students may learn most effectively within their predispositions. As an instructor of child psychology, moreover, the writer is especially interested in assessing the attitudes toward children that his students hold. Before studying the behavior of children, the student should know how he feels about them.

The purpose of the present study is to determine whether there is any relationship between the attitudes toward children that students hold and the attitudes they assign to their instructor.

After three weeks of lecturing about theories of child development, prenatal development and postnatal physiological development, the writer administered the Minnesota Teacher Attitudes Inventory (2) to his classes in child psychology. It was his intent to lecture formally about non-controversial topics so that the students would not be cued to the instructor's attitudes toward children. After the Minnesota Teacher Attitudes Inventory (MTAI) was administered, the students were asked to write what attitudes toward children they believed their instructor held.

The MTAI is a measure of the teacher's attitudes toward democratic procedures in teaching. The concept of democracy adopted by the authors of the MTAI is akin to good mental hygiene. The inventory is based on the F scale developed by Adorno and others (1). The F scale is a measure of authoritarianism or acceptance of fascis-

Mr. Chansky is an assistant professor of psychology at the State University of New York in Oswego.

tic attitudes. High scores on the MTAI suggest respect for the worth of children, belief in their ability to grow, and belief that each person has a place in the world. Low scores suggest aggression toward children; the seeking of security through virtue, position and authority; and the seeking of security through knowledge of the subject matter.

Working with a minimum of cues, 16 students felt their instructor would allow freedom of search and of communication, 12 felt that he would strongly insist on discipline in the classroom and on socially precise behavior; 9 that he would set himself apart from the classroom procedure and be very impersonal in his relationships with students; 12 that he would be patient and understanding in his relationships with children; 12 that he would respect children's status; 6 that he would have close personal contact with students; and 9 that his major interest would be in helping children who were having problems in school.

Examination of the MTAI scores indicates that students did not assign attitudes to their instructor by chance, nor did they necessarily assign them to him on the basis of cues he emitted.[1]

The students who assigned the attitudes of freedom to explore and to communicate what one has found had the most democratic attitudes toward children. The groups with the next highest MTAI scores saw their instructor as a patient and understanding person or they saw him as one who would have close personal contact with children. The students with the most pronounced anti-democratic philosophy of child development, saw the instructor as a person who would be primarily concerned with teaching children socially precise behavior or they saw him as one who would be primarily interested in helping children who have problems which interfere with learning.

A few quotations from students who participated in the study will illustrate these findings more clearly.

STUDENT A

MTAI score 72. 99th percentile for university freshman.

1. You believe in trusting students.
2. Students should have more class freedom.
3. Do not publicly embarrass a pupil.
4. Today's children are just as good as any other generations.
5. Children should ask questions.

STUDENT B

MTAI score –1. 40th percentile for university freshmen.

1. You are always interested in pupils who need help to understand the subject.
2. Students come to school for one purpose and that is to gain knowledge.

STUDENT C

MTAI score –19. 20th percentile for university freshmen.

I think that you regard the classroom as a learning place where pupil and teacher should experience an impersonal relationship and where the pupil is there to learn.

STUDENT D

MTAI score 84. Beyond 99th percentile for university freshmen.

You feel that children given the opportunity to express themselves will help teachers to understand them. These views are mine and I probably have been projecting my ideas to you since I haven't actually had

[1] The proof reported is qualitative. The precise statistical results on which this report is based may be obtained by writing the author.

enough time to understand your motives and ideas.

STUDENT E

MTAI score –20. 20th percentile for university freshmen.

I think you believe that the child should be brought up under a normal disciplinary program so when the child starts school he will have an idea of what discipline means. The child should be helped by his parents if he has a problem to overcome; however, he should not be given sympathy. The parents should also see that the child gets acquainted with the right class of individuals as other children have an effect on the personality of your child.

The above statements are but a few samples of the proof that students with democratic attitudes toward children see the instructor as democratic; students with undemocratic attitudes see him as undemocratic.

There are at least two theoretical explanations for these findings. One could say that the students projected onto the instructor, in the absence of defined cues, their own attitudes. On the other hand, one could say that the students who hold a certain attitude are more apt to be aware of its manifestation in the teacher because of their sensitization. That the latter is apparently not tenable may be inferred from the fact that there were no differences in MTAI scores between the group which assigned impersonal contacts and that of the group which assigned personal contacts to the instructor.

It appears, then, that students assign to the instructor attitudes toward children which they themselves hold. The students themselves appear to be aware that this is what they are doing. One can see too how freedom to communicate, patient understanding and close personal contact with students are related to democratic classroom procedures. Likewise, in confirmation of the findings of the Adorno group, the strong emphasis on socially precise behavior and on discipline is consistent with anti-democratic ideology. What is difficult to understand is why those students who felt the instructor was primarily interested in helping children with problems received scores which would classify them as anti-democratic. One guess as to its meaning is the strong dependency feelings of authoritarian personalities. Helping the children with problems may be a compensation for one's own dependency feelings or it may indicate identification with dependent or perhaps helpless children. Regardless of the interpretation, the finding is alarming. If helpless children are taught by teachers with authoritarian outlooks, it would stand to reason that their growth would be hampered rather than facilitated.

CONCLUSIONS

Attitudes that students assigned to their instructor reflected the attitudes they themselves held. Students who assigned their instructor such attitudes as freedom to communicate, patience, understanding and close personal relationships with children held democratic attitudes toward classroom procedures. Students who assigned the instructor interests in discipline and in helping children with problems held attitudes toward children that are not consonant with good mental hygiene.

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RALPH L. KOLODNY

Research planning and group work practice

The influence of the research process on the climate and function of a specialized group work department

The ultimate aim of research in the mental health professions is the improvement of professional service. The research worker in a social agency attempts to effect this improvement by helping the social worker to a greater understanding of the impact of his work on clients, members or society at large and by stimulating and aiding him to develop more effective ways of dealing with those problems of personal and social disorganization that are his special concern. While social work research can be thought of as the application of the scientific method to the data of social work experience, I have chosen here to describe its interactive and interpersonal aspects. For it is my feeling that in any discussion of research in social agencies or any other mental health field, constant emphasis must be placed on the fact that the application of this method involves the interaction of a person or group of persons with particular skills and a particular role with another group of persons with other skills and roles. The effects of the activity of the research practitioner on agency service are not only to be discovered in the extent to which the formal conclusions which come out of his study are put into practice. They are also to be found in the responses and reactions of

Mr. Kolodny, who is research supervisor in the department of neighborhood clubs of the Boston Children's Service Association, presented this paper November 27, 1956 at an institute on research and agency practice, held in conjunction with the Massachusetts Conference of Social Work. He wishes to express his indebtedness to the following staff and committee personnel of the department, whose work his paper describes: Dr. Kenneth Wollan, director; Miss Marjory Warren, director of group work; Dr. Samuel Waldfogel, research consultant; Dr. Eveoleen Rexford, Prof. Elizabeth Rice and Prof. Saul Bernstein, research committee members; Virginia Burns, Corinne Carr, Sheldon Abrams and James Garland, group workers.

social workers toward research itself and toward their own practice which are related to the manner in which the research practitioner carries out his research procedures day by day.

During the last four years the staff of the department of neighborhood clubs of the Boston Children's Service Association has been involved in planning, hoping for and inaugurating a research program. In the course of these events, we have gradually come to realize that the significance of a research program to a service agency lies not only in its findings but in the social processes set in motion by its initiation, administration and implementation. I would like to share with you some of the highlights of the experience that led us to this conclusion.

The department of neighborhood clubs is a rather unique operational unit. It is among the oldest of group work resources, having been established some seventy years ago. Yet in its present form, with its pioneering efforts in group work with emotionally or physically handicapped children, it represents the most modern of services. The department is a specialized group work unit functioning as part of a large multi-functional child welfare agency, the Boston Children's Service Association. The department operates on a referral basis. Physically handicapped or emotionally disturbed children who are suffering social isolation in their own neighborhoods are referred to the department by casework agencies, hospitals, clinics, schools or parents. They may be referred singly or in groups. The department usually forms clubs around these children in their own neighborhoods, feeling that whenever possible the problems such children face in their group associations should be worked through in the social settings in which they arise. The full-time staff of the department includes a director, 4 group workers and a research worker. Each of the group workers leads 4 or 5 groups. Other groups are led by group work students placed for training with the department or by graduate students in related fields (such as clinical psychology and education) who are hired by the department on a part-time basis. In addition to group leadership, full-time staff members and group work students carry on a substantial amount of individual work with group members and their families.

Clubs conducted by the department are of several general types. These are:

- Clubs formed around one physically handicapped or emotionally disturbed child who is referred to the department by a casework agency, clinic or hospital. Each of these groups is composed of one referred child plus a number of other children from his own neighborhood. These other children are presumably youngsters whom the referred child ordinarily would associate with, were he less handicapped or disturbed. The majority of the groups conducted by the department are of this type.

- School groups. At the request of several school guidance departments, the department has established groups in various suburban communities. Each of these groups is composed of children from a number of different schools in the community, all of whom have experienced marked difficulty in their social relationships.

- Clubs of pre-delinquents. Each of these clubs is composed of the members of a "natural" group which has engaged in anti-social activities and which, as a group,

has been referred to the department for service by group work or other agencies.

• Institutional groups. Groups of this type are composed of children who are resident in special homes and schools where they have been placed for one of a variety of reasons: family disorganization, delinquent and pre-delinquent behavior, emotional disturbances and severe physical handicaps. In each instance the worker from the department comes to the institution weekly to lead the group.

Approximately 30 to 40 clubs are worked with each year by the department. The age range covered is 7 to 16 and the children referred are of both sexes. In 1955, for example, 312 children were members of department clubs. Of these, 130 were referred children (that is, children who had themselves been directly referred by an agency for service, either individually or as members of a referred group). The other 182 were children who joined clubs in their own neighborhoods which were formed around children referred individually for service. The approach employed by leaders in their work with these groups is based on the theory that the disturbed or handicapped child referred to the department for service can modify his behavior and improve his adjustment to his peers through being exposed to activities and relationships in which he can test out and achieve with the active support of a trained leader. Through this process, it is believed, the child becomes aware of his own strengths and capacities. Department leaders focus on helping the referred child to develop an awareness of his own strengths and capacities for social relationships with his peers.

The department's practice, as is obvious from even the foregoing brief description, offers a rich and complex field for research. A substantial paper might be devoted simply to the methodological problems involved in its exploration. While I shall try to present an overview of the contents of our present research program, however, my primary concern will not be with methods *pe se*. Instead, I shall concentrate on the history and background of this program in an attempt to indicate the influence which the process of developing such a program has had upon the department and its service.

It might be well to reverse our chronology a bit at this point in order to highlight this matter of process. Let me therefore first describe the scope of our present research efforts and then go back to the time when the subject of research in the department was first broached. My primary concern will be to describe how this idea of research grew, what steps were taken to implement it and how thinking in research terms affected the practice of the workers involved.

At this stage our research is exploratory in nature and our basic research method is clinical. Through the analysis of record material by the research worker and the sharing of direct experiences by group workers in regular staff research conferences we are attempting to clarify for ourselves the dynamics of the processes which we employ and set in motion in our work. Our objectives are: (a) to increase our awareness of what we are doing and (b) to provide the rapidly growing number of our colleagues who are interested in group work with handicapped and disturbed children with concrete observations on the kinds of problems likely to be encountered in this type of work and on some of the methods available to the practitioner in dealing with them.

Because of the complexity of the processes involved and the wide variety of situations in which workers function, it has not been possible to use experimental techniques in our study. We have made little use of quantification. We have not attempted a systematic analysis of our total practice. What we have done is to take a number of problem areas or problem issues in our work, examine some of their crucial features and organize our experiences in relation to them in such a way as to make more explicit our procedures and the theoretical assumptions that lie behind these procedures. Our research program this year therefore has consisted of the following parts:

RESEARCH AT THE DEPARTMENT'S SUMMER CAMP

The department conducts its own summer camp, Bonnie Bairns, some 20 miles south of Boston in Cohasset. Each department club comes to our camp for an 11-day period. The members of 5 or 6 different clubs attend camp at the same time. Camping is an important part of the department's total operation. In the summer of 1955 we decided to analyze the behavior of a segment of our camp population in order to indicate the possible implications of this behavior for general camping practices *vis-a-vis* disturbed and handicapped children. For this purpose we carried out an observational study on a club group of 5 extremely disturbed adolescent girls who also suffer from physical handicaps of various types. Using the entire counselor staff as observers, we made careful day-by-day notes on the manner in which these girls, as individuals and as a group, responded to other campers and to the attempts of staff to integrate them with the rest of the camp population. We collected the observations made by the camp staff and then analyzed them, setting out the problems and methods that came to light and interpreting their possible bearing on general camping practices with "deviant" children.

Collection of the data was carried out in the summer. Its analysis occupied the major portion of the research worker's time during the fall months. This camp research was reported in abbreviated form in an article that we wrote entitled "Specialized Camping for a Group of Disturbed Adolescent Girls," which appeared in *Social Work* in April 1956.

RESEARCH ON ORGANIZATIONAL PROBLEMS IN DEPARTMENT GROUPS

For purposes of study we have differentiated 8 major aspects of the department's process of treatment. Modifications in the procedures employed by workers in relation to these various aspects occur in each case depending upon whether an individual or a group was referred for service and on the type of club that is formed. These aspects of treatment are not separate or strictly sequential and the worker usually carries out the procedures involved in two or more of them, concurrently. They include:

1. The referral.
2. Developing an initial working relationship with the referred child (or children) and his (or their) parents.
3. Forming the club group.
4. Structuring and guiding group composition, activities and relationships.
5. Relating the activites of the group to the experience of members outside of club meetings.
6. Individual work with group members and their families.
7. Continuing cooperation and involvement with agencies active in the case.
8. Termination.

During 1955–1956 an important part of our research program was devoted to an analysis of the problems involved in the first three steps listed above and to devising methods that might be used in dealing with them. All full-time group workers, the research worker and the research consultant participated in the discussions dealing with these problems. The three aspects of treatment that we studied encompassed the preliminary organizational procedures used by the department. It is our feeling that the manner in which these procedures are carried out has a fundamental influence on the future course of events in every case and that careful handling by the worker of the problems related to organizing and forming a group is basic to the later optimal functioning of that group.

The experiences of workers in 7 of our most difficult cases, as described in record material and verbal presentations, were used as the basis for this study. In each case major problems in work with the group had been encountered which could be traced back to unresolved difficulties during the very early stages of the worker's relationship with group members and their parents. The purposes of our analysis of these cases were to (1) discover the crucial issues involved in our organizational procedures, (2) arrive at principles which have relevance to the handling of these issues, primarily those relating to the initial resistance of referred children and their parents to service, and (3) help staff members to apply and test these principles in their actual work with group members and their families.

We arrived at a number of broad principles on the basis of our analysis. It would be inappropriate in this discussion to go into these principles in any detail. But I might illustrate the type of principle to which I refer by the following two statements around parental resistances:

1. Department workers have contact primarily with the mothers of physically handicapped referred children, although substantial contact with fathers occurs in some cases. Every mother of a referred child is ambivalent to some degree toward her child's entering a group. In some instances, however, resistance is particularly great. Some of the anxieties that lie behind this resistance are fear that the child will "fail" in the group, fear that the group will "contaminate" or be dangerous for the child and fear of "losing" the child to outsiders. If a mother preceives the proposed group for a child as primarily dangerous and threatening and there is little perception of its potential helpfulness, then we must attempt to discover what her anxieties are and to help her to talk about them. If we proceed with plans to form the group without regard for her anxieties, difficulties will arise at a later stage of the group's development. In handling the anxiety that is initially shown, the best techniques for our purpose appear to be the simple ones of accepting the mother's presentation of these anxieties, listening, respecting her fears rather than trying to expose their irrationality and indicating, through the tone and content of our comments, that we are not going to "take her child away" from her.
2. In some cases the mother feels very ambivalent about the club group once it is underway. She resents her child's being "taken away" from her by the group. On the other hand, she keeps the group away by resisting having any group meetings in her home. In such situations, close attention must be paid to the mother's as well as the child's needs. If a caseworker is not seeing the mother, it is important

for one department worker to continue working individually with the mother, "giving" her something to compensate, in part, for the "loss" of her child and handling some of her hostility, while another worker leads the group.

CRYSTALLIZING OUR THINKING ON KEY PROBLEMS

The work of the department is of interest to group workers in a variety of settings. In the field of service to the physically handicapped, for example, the department each year receives communications from agencies in different parts of the country, asking for particulars on our methods of operation. The department is interested in developing guide lines for practice that can be useful to workers in these and other agencies serving children who are socially isolated. We aim to do this in part by organizing, in such a way that it can be more effectively shared with other practitioners, some of the recorded material we at present have. Part of our research effort therefore has been devoted to the writing of two monographs on our practice. These monographs do not purport to provide ready answers to critical problems in group work with handicapped or disturbed children. They do, however, describe the range of problems we have encountered in our practice, some of the different ways in which they are manifested, and many of the methods our workers have found useful in attempting to resolve them. This material can furnish group workers who in other agencies are carrying on types of service which are in some way similar to ours with the means to prepare themselves for dealing with the problems they are likely to encounter.

The tentative titles of these monographs are *Therapeutic Group Work and the Physically Handicapped Child* and *Experiences with Therapeutic Group Work in Neighborhood Settings.* The first includes both theoretical and illustrative material based on our experiences with physically handicapped children. It deals with topics such as evaluating the use a child may make of the group experience, determining objectives, preparing the child and his parents for the group experience and the like. The second monograph is designed to illustrate concretely some of the more important aspects of a department worker's function, by describing work done in five different groups. The research worker has primary responsibility for work on these documents, but three other department workers are participating extensively in the writing, as well.

ADDITIONAL RESEARCH

During the summer of 1956 we again studied the same group of girls whose behavior we analyzed at camp in 1955. Our methods were similiar to those we used last year and our attempt was to discover any changes in the ways in which these youngsters made use of our camping resource.

During the current year we are continuing with our research on the eight steps involved in our work. We are presently focusing more directly on the workers' techniques of leadership as they affect referred children in our groups. We have begun with an intensive study, through analysis of record material and staff discussions, of the ways in which, in groups formed around one referred child, the referred child manifests his basic emotional problems, how the other members react to the unacceptable features of his behavior, and the forms of intervention and the kinds of program activities used by the leader to mediate the crises which develop. The purpose of this

study will be to clarify and improve the methods used by department workers in helping referred children to relinquish or modify inadequate and inappropriate behavior in social situations. As a project related to the foregoing, we are tentatively planning an investigation of the phenomenon of support, as it is manifested in our groups. The research worker will not have primary responsibility for work on this problem; instead, a staff member with the necessary background and qualifications is to be assigned to this project one-half day a week.

The type of research program just described necessitates close and regular contact between researchers and other staff members. The group workers quite literally become researchers themselves. They are constantly involved with the research personnel in describing, classifying and analyzing their own work. They share directly in the first attempts of the research personnel to grasp the problems of the service to be studied, they share the confusion and the doubts of research personnel as they attempt to find a way into the data, and finally they help in the formulation of a research plan.

Such intensive contact and mutual involvement has its disadvantages, and indeed its dangers. At the department of neighborhood clubs, however, it has been our distinct impression that the benefits of this type of research operation far outweigh its negative features. This impression is based on our perception of certain positive developments in the department from the inception of the research idea down to the present time.

What were these developments and what was the process in which they had their origin?

By the fall of 1951 the department had moved fully into the area of service to physically handicapped and emotionally disturbed children. Increasingly, cases were being referred which presented a whole battery of severe problems. Relationships had been established with agencies of many different types and on many different levels. Instead of one professional worker supervising a number of volunteers there were now a supervisor and two full-time trained group workers on the staff. In view of these developments, the director of the agency and the head of the department felt that it was extremly important that an organized process of self-study be instituted in the department. The content and methods of this study were not defined, but the general idea was that it was to help answer the question "Who can best be helped by the type of service that the department offers?" The two department workers proved to be very much interested in the idea of research when the subject was presented to them, and together with the head of the department they drew up a series of questions related to the department's practice which they felt a research project might help them to answer. This list of questions was used by the agency and department directors in interpreting the need for research to the agency's board. Those board members most closely concerned with the department were very receptive and although funds were not available for research at the time the agency director was empowered to explore the possibilities of securing a research worker and research funds. When I, as a group worker, applied for a position with the department in 1952 funds had not yet been obtained. Note was taken of my graduate work in sociology prior to social work training, however, and an arrangement was made whereby I would come on the staff

as a group worker, would become well acquainted with the service of the department, and upon the securing of funds for research would move into the position of research worker.

The department proceeded on the assumption that money for research would eventually be forthcoming. We therefore began, even at this early date, to set up an administrative structure for the project and to move into discussions on research methodology. A small but regular period of time was allotted by the staff for weekly research meetings. A research committee was formed. Two members of this committee—a psychiatrist and a group work educator—were already part of the committee which oversees the work of the department and they were eager to join the research committee. Two other members were secured from the fields of clinical psychology and medical social work. This committee provided us with experts in four fields intimately related to the department's work, all of whom had previously been involved in research projects, some of them quite extensively.

From the beginning, planning went ahead on both the committee and staff levels. Each of these two groups were regularly apprised of the thinking of the other. All through this period our lack of money for full-time research was, of course, a matter of concern to us. Yet it had its positive aspects, for we were compelled to organize some of our thinking and our material in order to have something tangible with which to approach foundations for funds. As a result, staff members, working closely together, developed a formal request for funds. This included a description of the department's history and function, summaries of work done with specific children, and a statement on the potential values of research in this setting.

The process of gathering this material had implications for the department's practice which workers were quick to see, for it reemphasized the necessity of the department's constantly maintaining accurate and usable accounts of its operation. This process had other ramifications as well. An important part of the request for funds, for example, consisted of a list of general approaches to common problems which was compiled by staff. Among the 9 situations considered were (1) working with the parents of the referred child, (2) forming the group, (3) handling aggressive behavior on the part of the referred child, and (4) helping other members to accept the referred child's handicap. After describing these situations the staff then together spelled out the approaches they agreed upon as being commonly used and most likely to be successful in these situations.

I was struck by the effect which the procedure of compiling and working on this list appeared to have on the thinking of staff members and, at the time, I wrote the following: "One should not be disarmed by the apparent simplicity of this list and therefore neglect its implications. The process of cataloguing, classifying and systematizing lies at the heart of research. Beyond this, when fed back into the day-to-day work of the department, it has a great deal of practical meaning. Such a classification of techniques enables the group leader to draw with greater facility upon the experience of other group leaders. For the new worker especially, but also for the old, it provides, when completed, a body of knowledge to which he can refer for concrete help. In this process of organizing their experience, workers assume, at once, the roles of 'learners from' and 'teachers to'

each other. The experience becomes, thereby, both a supplement to and an extension of the normal process of supervision." [1]

The complexity of the research problem warranted the retaining of a research consultant on a part-time basis. The agency director strongly supported this idea and was able to make a successful interpretation of the need of its implementation to the board of directors. Dr. Samuel Waldfogel, director of research at Judge Baker Guidance Center, who was one of the committee members, was asked to take this position of research consultant and accepted.

The research consultant and research worker then began an examination of the department's operation in order to discover those areas of its work which staff felt were most important and to develop that research approach, either clinical or experimental or a combination of the two, to which departmental data and practice seemed best to lend themselves. It is important to note that the two persons primarily concerned with the research were not then carrying on their activities independent of the rest of staff. On the contrary, their work involved the cooperation and active participation of staff workers at every turn. As part of their exploratory work, for example, the research consultant and research worker were interested in how the group workers defined "success" and the kinds of criteria workers used in evaluating outcomes in their work. Workers were first asked to select that group in which they felt they had been most successful in terms of the improvement shown by the referred child and that in which they had been least successful. They then were requested to describe in narrative form their reasons for considering the results of their work as good or poor. The findings of the research personnel in this connection are important, but what concerns us here is the effect of this research procedure on the thinking of staff members. By looking back on their own work, staff members were enabled to make their goals more concrete and to set them down in more specific fashion. In their own minds, for example, they could no longer accept a goal such as "socialization" without delineating for themselves in a more clear-cut way the behavior manifestations and changes which indicate to them that a child may be becoming "socialized."

The importance of recording was also given further impetus by the research process. The activity of the research personnel included the examination of records on specific individuals and groups. Conferences were held in which workers described in some detail the problems met and approaches used to overcome them in the groups being considered. This process involved the expansion and supplementation of record material. Through it, workers were helped to discover areas in which their recording might be changed. Most important of all, perhaps, this process highlighted for workers the fact that their records were being systematically and concretely used. Nothing is more conducive to a worker's morale in this matter of recording than the realization that his records are really useful.

Let me say, parenthetically, that we have not overcome worker's problems in recording through our research efforts. In some respects, workers have been inhibited in their recording output because they are

[1] Ralph L. Kolodny, "The Research Process—An Aid in Daily Practice," *The Group*, 16(October 1953), 18.

anxious to write records of high quality. The realities of limited time and a heavy work load also cannot be easily eliminated. But the feeling of workers that their recording is central to their practice has certainly been heightened by the introduction of a research program.

The intellectual climate of a department or agency is a difficult thing to assess. It was the feeling of staff members generally, however, that during this first year of "research thinking" changes took place in this climate. The constant process of questioning had a subtle but definable effect on the outlook of staff members. Through their involvement in the research process, workers were helped to move from a point where, confronted by a particular development in the group process, they thought "Isn't this interesting? I wonder what it means" to one where they asked themselves "How important is this development? Have other workers seen this in their groups? When is it likely to occur? Are there any changes in practice which should be made to deal with it? How can it be studied?" Research thinking gave rise to more purposeful staff discussions, to wider professional study and reading, and in general to more thoughtful practice.

Throughout this period it was necessary to compile a number of facts, statistical and other, about numerous areas of the department's operation. Material previously deposited under widely scattered headings, and sometimes not even written, was assembled into some kind of coherent whole. In interpreting the work of the department to committees, board and other agencies, workers were thus provided with an organized fund of information to which they had easy access. The research process thus helped to provide a more solid foundation for the interpretation of group work practice.

During the two years which followed this initial period of research thinking, arrangements were made for me, as research worker, to devote a greater amount of time to research planning and to carry less than the usual group load as a worker. Two group workers were also added to staff. Funds for research were still not forthcoming, but because of the director's feeling that the prospects of securing money for full-time research were still good and because of the conviction of everyone on the staff that the process of research planning was having a direct and positive influence on practice, the board and department committee were amenable to an increase in research time.

The research consultant and worker at this time turned their attention to developing a full-blown research prospectus which could be submitted to various foundations. Meanwhile, the research committee, with the agency director taking primary responsibility, sought channels for financial support. During the first year of planning our thoughts had been inclined to an evaluation of our work in each group in terms of the "movement" of the referred child in the group, using some sort of scaling device for this purpose. We have never given up this idea completely. The difficulties of constructing a valid and useful measuring device, however, and our questioning as to how much such a measuring project would really tell us about our practice, led us to a different research approach. We began to think of research in terms of a clinical study of our treatment process, with a concentration on what we do, why we do it and what its apparent effects are on the behavior of the children with whom we do it. We came to share Elizabeth Herzog's feeling that ". . . the 'how well' kind of research needs to be done, but . . . it contributes more to administrative considerations than to therapy

and practice. . . . Research geared to the question 'what are we doing?' will in the long run contribute more to all." [2]

The research worker and consultant worked with the group workers in isolating the major steps in the helping process they employ with their groups. Together they set down the numerous procedures involved in each of these steps and raised what they felt were the crucial questions about each of these procedures. This was the staff's project, not the director's or department head's or research worker's alone. The staff verbalized their feeling that in the very process of setting out their practice in an organized way they became more aware of its problems and its implications. Regular once-a-week research discussions were instituted. As these, in line with our research approach, were concerned not simply with the results of practice but with techniques, methods and theories, the research consultant was able to provide extremely valuable suggestions, from a psychodynamic standpoint, as to the meaning of the behavior observed by workers in their groups.

To be sure, there are tensions in the carrying out of this kind of research approach. The process of articulating and examining one's own practice that is involved and the growing self-awareness that is an accompaniment are not without their painful aspects. Three factors, however, tended to dissipate the major tensions in this case. The first was the constant experience of mutual help and regard which the research meetings provided for workers. The second was the example of the department head, who took a leading role in laying open the department's practice for examination. The third is to be found in the activity of the agency director, who gave constant recognition to all of those involved in the research effort and who worked so hard in seeking out sources of financial support.

In the spring of 1955 our efforts finally resulted in the securing of a grant for research.[3] I moved into a full-time research position and we set about to plan the research program I discussed in the early part of this paper. We also organized our ideas for presentation to the research committee. Shortly thereafter we formally embarked on our study. During the year that has gone by since the formal beginning of the project, the staff has continued the same pattern of involvement in research planning that was described above. Our practice of holding weekly staff research meetings has continued and research has become not an adjunct to the department's service but, rather, an essential part of it. The research process itself has continued to be a source of stimulation to those doing the actual group work. Time does not permit a detailed exposition of this point, but a brief reference to our experience in carrying out research at camp may illustrate its meaning.

The task of "doing research" in any camp situation is an arduous one. In a camp such as ours it becomes even more difficult. Confronted, frequently, with provocative, disturbed and even bizarre behavior on the part of many campers, counselors may soon find themselves with little enough energy to cope with problems in working with campers, let alone with enough energy to organize, record and report their observations. Although our counselors were

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[2] Elizabeth Herzog, "Put First Questions First in Evaluative Research," *Casework Papers from the National Conference of Social Work.* New York, Family Service Association of America, 1954, 150.

[3] The department's research program is now supported jointly by the Charles H. Hood Dairy Foundation and the Warren Benevolent Fund, Inc.

genuinely interested in the research idea, it would not be accurate to state that they were happy about the amount of work involved and the filling up of already top-heavy schedules with daily research meetings. Despite their natural resistances, however, this past summer, for example, these counselors turned out a substantial amount of thoughtful material and, by and large, made copious notes on their observations. Several later stated that involvement in research made them more sensitive to individuals. Many of them voluntarily used the same system for making and taking down observations on groups which came to camp after the research project had been completed. A number of counselors, later in the season, even asked if they might write up particular incidents at camp to illustrate certain principles and techniques. They carried through on this idea and several of the anecdotes they submitted are being used in this year's report on camping to the department committee.

What we might say, apropos of this development, is that participation in a research project can heighten the feeling of the worker that someone considers his impressions and experiences to be of great value. This stimulates him to set down his observations more frequently, more systematically and more thoughtfully.

Three years ago I listed the following as the contributions which the research process itself made to practice, as seen in the experience of our department. I still consider these to be the basic contributions of research in this connection. Let me then restate them here. The research process:

1. Makes for clearer thinking and greater accuracy about the goals of practice.
2. Leads to a better understanding by workers of the place of their work among the many environmental forces influencing behavior.
3. Stimulates increased idea-sharing among staff members.
4. Provides workers with more practical knowledge of how to deal with problem situations.
5. Supplements and extends supervision by placing workers in the position of both "learners from" and "teachers to" each other.
6. Heightens staff interest in and morale around recording.
7. Introduces a climate of reflectiveness, leading to more purposeful staff discussions and to wider professional study and reading.
8. Provides a coherent body of facts from which fuller and clearer interpretation of practice can be made by workers.[4]

I might add one final item to this list. Research helps in attracting and holding competent staff.

All of these elements mean better practice and more effective help to those we serve.

[4] Kolodny, *op. cit.*, 24.

Book Reviews

THE MENNINGER STORY

By Walker Winslow

New York, Doubleday and Company, 1956.

This is the saga of a remarkable Kansas physician who sired and inspired two famous psychiatrists—Drs. Karl and William C. Menninger—and, with them, founded the clinic that turned a small city on the midwestern plains into the American mecca of that most cosmopolitan of medical arts, psychoanalysis. Today mental health students and experts from all over the world beat a path to Topeka, where, in 1890, 28-year-old Charles Frederick Menninger hung up his shingle as a general practitioner so straitened financially that he could barely afford to buy a bicycle, much less the traditional horse and buggy.

Nine years ago Walker Winslow, using the pseudonym, "Harold Maine," authored an excellent account of his experiences in mental hospitals, first as an alcoholic patient, then as an attendant. In his new book he goes beyond the biography of an individual to present a portrait of a family of sharply diverse personalities whose qualities somehow meshed to make possible one of the most impressive medical success stories of our time. Winslow executes it sympathetically and honestly.

Dr. Menninger was the epitome of the good physician with the little black bag—gentle, kindly, self-assured, deliberate in action, dignified yet warm. He was ever eager for new scientific knowledge that could help him help his patients. At a time when some of the drugs in the average doctor's arsenal killed or crippled as often as they cured, Dr. C. F. brought into the sickroom one of the most potent therapeutic weapons—hope. He studied medical literature endlessly, attended scientific meetings and visited great medical centers at every opportunity, in order to improve his art.

A dominating influence in Dr. C. F.'s career was his wife, Flo, a student whom he married at 23 when he was professor of natural sciences at a small Kansas college. Flo Menninger was a woman of tremendous drive—industrious, ambitious for her husband, strait-laced (she never permitted drinking, smoking, dancing or card-playing in her home), intensively absorbed in Bible-reading, with a compulsive passion for teaching (she'd rather teach than eat). She had two pet aversions—idleness and extravagance. She was frugal to the point of penury (except in relieving personal distress, when her heart and purse opened wide). Her niggardliness stemmed from a hard, fun-starved, misery-ridden childhood. But Flo was a devoted wife, adored by her husband, and a loving mother to her three sons—Karl, Edwin and William Claire. She inculcated in all a spirit of intense effort, of dedication to whatever task or trust they undertook.

Dr. C. F. became a leading Topeka doctor, but never ceased his efforts to make himself a better one. He was shocked by some excrescences of competitive private practice. He saw, in his day, individual doctors hoard knowledge of new healing discoveries and devices as "trade secrets" that, if shared, might save the lives of many children and adults. He saw his own efforts to share medical information thwarted by indifference, suspicion and greed. In 1908 he visited the Mayo Clinic in Rochester, Minn., the classic example of group medical practice, where doctors work as teams, pooling their skills, know-how and equipment. At the breakfast table upon his return to Topeka, he expressed the solemn hope that his three sons would

become physicians and help him build a group practice clinic. When Karl and Will returned from Harvard and Cornell with medical degrees, the dream became a reality. (Edwin, the middle son, got sidetracked from medicine through a laboratory accident and became a newspaper publisher in Florida.) Dr. Karl infected his father and younger brother with his own enthusiasm for psychiatry. Dr. C.F., a prominent physician in his own right, eagerly and humbly sat at his son's feet to learn about the burgeoning specialty. The Menninger Clinic developed into what is today one of the world's largest psychiatric training centers, outstanding also in psychiatric treatment and research.

It was typical of Dr. C.F. that, as he lay on his deathbed in 1953 at the age of 91, he carefully described his subjective symptoms as a contribution to medical knowledge and, with his dying breath, praised the attending physician for his fine work.

The Menninger Story lacks the fine writing which featured Winslow's earlier book, *If A Man Be Mad.* It is occasionally stilted and repetitive. The author doesn't always avoid the temptation to indulge in amateur psychoanalysis of the psychoanalysts. On occasion he narrates personal details that may embarrass living characters without adding to his story. But on the whole *The Menninger Story* unfolds itself as an engrossing tale of an extraordinary American family.—ALBERT DEUTSCH, Washington, D. C.

SOCIAL WORK
YEAR BOOK 1957

Russell H. Kurtz, ed.

New York, National Association of Social Workers, 1957. 752 pp.

This 13th edition of the *Social Work Year Book* is the first to be published by the National Association of Social Workers. (The previous editions were published under the auspices of the American Association of Social Workers, one of the organizations comprising the new NASW.) It follows the pattern of the earlier editions and as is usual with professional yearbooks can be read independently of the others. Special emphasis has been placed on bringing the material up to date since the publication of the last *Social Work Year Book* in 1954.

The categories in this edition are in three main divisions. Part one contains three articles dealing with the historical background and present context of social work in the United States. The first of these considers the development of social welfare programs, the second discusses the economic context of social work and the third discusses its cultural context. In the opinion of the reviewer, the addition of these three articles is the most significant new contribution in the entire volume.

In the article on the development of social welfare programs, H. L. Lurie has presented a well-written and well-documented account of social welfare development in the United States from the colonial period through the post World War II era. In writing about the economic context of social work in this country Ewan Clague has summarized the economic factors which influence the current welfare picture. The third article, written by Herbert Stroup, presents a frame of reference for social work within the cultural pattern of present-day society. Mr. Stroup's closing paragraph might be considered an overall summary of this historical approach to social work in the United States. He states, "Thus, social work finds itself today in the midst of a rapidly changing society in which it is called upon constantly to adjust its ideas and services. Social work in the

past has shown ability to change with the social requirements. The challenges it faces today may well enable it to respond with conceptual structures and social programs which will help the general citizenry to extend even further the full meaning of democracy in American life." Social workers should find this a succinct statement of the problems as well as the goals of social work and social welfare, namely, that there are indeed constant changes to be faced and adjusted to, as well as challenges to be met, in furthering the democratic principles on which social welfare needs to be based.

Part two of the 1957 *Social Work Year Book* contains 68 topical articles by various authorities. The first is a consideration of the administration of social agencies and succeeeding articles comprehensively review areas of current social work thought and practice. The various topics are alphabetically arranged and contain many cross-references, which add to their value in a resource volume.

In contrast to the *Social Work Year Book* of 1954, which contained 72 topical articles, the current issue has not necessarily eliminated any vital material. For instance, instead of five separate articles on the physically handicapped—the blind, the deaf, the epileptic, *etc.*—this issue discusses services for those so disabled in one general article. Instead of a separate topical article on migrants, transients and travelers, the 1957 yearbook discusses services to these groups under special types of social work. Although some of the individual headings have been altered or even eliminated, such as those on labor and social welfare or labor standards, the 1957 volume, if anything, has broadened its scope and become more inclusive of the overall national social welfare field. Five new topical articles have been added. The new article on supervision in social work is a welcome addition since the concept of supervision as developed by the profession of social work might well be considered a unique contribution of this profession. Also, the concept of supervision is basic to both social work education and social work practice.

Although the *Social Work Year Book* primarily covers social welfare and social work programs within the United States, there also are two articles dealing with Canadian social welfare and international social welfare. Almost all of the articles contain cross-references and each is followed by a bibliography relating to the material contained in the discussion.

In general, the topical articles describe activities and programs in the broad social welfare and social work fields rather than in relation to individual social agencies. It is commendable that the authors do not present individual points of view or personal opinions but rather objectively present historical and current facts and information regarding their subjects. One might wish to give individual credit to each of the authors of the 68 topical articles but this obviously is impossible. Suffice it to say that the articles on the whole are well prepared, the writing often scholarly and the entire book thoughtfully compiled and edited.

Part three, a directory of agencies, is in four sections covering international agencies, national governmental agencies, national voluntary agencies, and Canadian agencies. This directory also adds considerably to the book's usefulness as a reference tool.

It perhaps is understandable that volumes of this size cannot help but omit some specialized areas of practice or philosophy. For instance, the reviewer noted with regret that in the discussion of mental illness and mental health and in the article

on psychiatric social work the authors emphasized mental illness and the mentally ill patient and gave only a nodding recognition to the 100 child guidance clinics emphasizing prevention, the development of which contributed so much to the whole field of mental health. Likewise, the American Association of Psychiatric Clinics for Children, the national organization and standard-setting body for these clinics, is not referred to in the body of these articles. It is, however, listed in the directory of agencies. Other such omissions may be apparent to readers identified with a particular field of practice, yet on the whole the 1957 *Social Work Year Book* achieves the purpose for which it is intended, namely, that of a reference and resource book.

As is true for the earlier editions, this volume should prove of value not only to social workers but also to other individuals, both lay and professional, such as teachers, board members, legislators, etc. To the non-professional reader, the volume should give a well-rounded general impression of the history, problems and programs of social welfare and social work, and the professional social worker would do well to make it a part of his professional library.—MARJORIE R. LANDIS, Lehigh Valley Guidance Clinic, Allentown, Pa.

TEACHING THE BRIGHT AND GIFTED

By Norma E. Cutts
and Nicholas Moseley
New York, Prentice-Hall, 1957. 268 pp.

This book is in line with the modern trend of making teachers of every subject the key persons in the education of gifted students. It is directed to teachers, recognizes their points of view, deals with their problems and describes procedures they can use in the classroom. The focus on the teacher never wavers; it is maintained persistently and consistently throughout the book.

This book fits into the present pattern of publications on the gifted. From books and articles on the waste of human resources, from research on the nature of the gifted, from the many descriptions of programs and procedures and from controversies about acceleration and homogeneous grouping, the authors have extracted whatever is pertinent for the teacher and have added much original material. They have written extremely simply to present no unnecessary reading difficulties.

The table of contents defines the scope of the book—from identification of the gifted to their educational and vocational guidance. The gifted must first be identified. After they are identified, the role of the teacher is to provide the educational experiences they need in heterogeneous or special classes by enriching the curriculum and going beyond the school to the utilization of community resources. Enrichment, however, does not mean neglecting the fundamentals. In many cases, attention must be given to the under-achievers among the gifted and to mental health and character development. Educational and vocational guidance are especially important for the gifted because they have such a wide choice of educational and vocational opportunities open to them. Parents, too, enter the picture at all stages of the gifted individual's development.

All these aspects of the education and guidance of the gifted are treated in separate chapters—25 in all. In addition, a list of the publications to which specific reference is made in the text—a classified, carefully selected, recent bibliography—is given at the end of the book. Some attractive photographs aid the reader in visualiz-

ing gifted children of different ages engaged in different kinds of appropriate activities.

Obviously so many topics cannot be treated intensively or illustrated with cases or situations subtly analyzed with reference to all their psychological ramifications. The treatment tends to be specific and prescriptive, as in the following paragraph: "When the parents are divorced or when parental relations are strained the child feels very insecure. You can help him by taking time to give him some individual attention. Do everything you can to make him feel he is somebody in his own right, that he can win your respect and liking. Give him things to do for you, and express your thanks. If he talks to you about conditions at home, reassure him as to his own future. If he thinks a divorce is pending, explain that he will surely be taken care of. Get him to discuss his own vocational plans, and show him how he can still carry them out" (p. 158).

Teaching the Bright and Gifted is eminently a practical, not a theoretical, book. The reaction of a teacher who reads it is likely to be: "This is something I can do" rather than "This is something new or baffling to me." It makes teaching the gifted in any classroom seem plausible and possible.—RUTH STRANG, Teachers College, Columbia University.

ON THE EARLY DEVELOPMENT OF MIND; SELECTED PAPERS ON PSYCHOANALYSIS

By Edward Glover

New York, International Universities Press, 1956. 483 pp.

Out of 169 papers on psychoanalysis written by the author during the years from 1922 to 1955 he has chosen 28 which he considers as having a direct bearing on the early development of the human mind. These writings, somewhat revised and condensed, he uses as chapters for this book, prefacing each with a short summary of the ideas and aims of his discussion.

Dr. Glover follows closely the theory of Freud that the basic organization of the mind takes place in the first five years of life as the child gradually becomes adjusted to inner needs for instinctual satisfaction and to the environment of persons (usually his parents) who in the main gratify or else frustrate his demands. In systematic and scholarly fashion Dr. Glover discusses the primitive psychological mechanisms used by the child in dealing with frustration and anxiety, and how these devices may become overcharged because of traumatic experience and congenital anomalies. In this way fixations occur at various critical phases of development and the early mental organization becomes distorted. He then goes on to emphasize that these fixation areas become overloaded with fantasy activity and thus predispose the individual to symptom formation under conditions of stress. His chief aim is to correlate etiologically the specific mechanisms found most consistently in the mental content of certain neuroses and psychoses with those defense devices characteristic of consecutive levels of psychic development where fixations have occurred. He considers that the repetitive overuse of these early mechanisms in early childhood establishes the area to which regression takes place in mental illness.

The author attaches the greatest importance to the development of the ego in early life and to the danger of its becoming weakened in relation to instinctual fixations, hence lagging in its growth into a strong and mature force for the orientation and protection of the individual. He has contributed an original theory of ego

development, namely, that from birth through most of the second year the ego is present as a composite of nuclei which are related to the various bodily devices for self-preservation, such as eating, grasping, body propulsion, elimination, and to perception. These nuclei or "islets" separate at first, begin to become channelized and integrated at the end of the second year, until which time this structure is extremely vulnerable. This theory is elaborated in Chapter VIII, Grades of Ego Differentiation. In Chapter XX, The Concept of Dissociation, Dr. Glover explains at some length how this theory helps to clarify the notion of ego-splitting in the psychoses. To this reviewer this is one of the most important chapters but is difficult because of the omission of clinical material. It closes with an interesting definition of the strong ego and its qualities: "elastic in adaptation, labile in mood but with capacity for happiness—or at least tranquility, freedom from unconscious guilt and anxiety, good working capacity and elastic response to working stress; regressional activities limited to the necessity for psychic recuperation."

Among the other most interesting chapters is the series of four which seem to belong together: The Mouth in Psychoanalysis, The Oral Character, The Etiology of Alcoholism, and On the Etiology of Drug Addiction. Out of a rich clinical experience the author defines and amplifies the mechanisms found in the addictions, laying special emphasis on the sadistic impulses and on failure in the development of libidinal drives. He thinks of certain types of addiction as "localized defects in the reality sense." The psycho-sexual problems associated with these "transitional states" between neurosis and psychosis, as he terms them, are discussed with clinical illustrations.

Chapter XIII, The Relation of Perversion-Formation to the Development of Reality Sense, points up the idea that the study of cases of perversion and fetishism gives strong evidence as to the course of development of reality sense.

Chapter XIV, Medico-Psychological Aspects of Normality, is an attempt to clarify some working standards of normality. The author postulates with sympathy the "normal" neurotic and psychotic states of the 1, 2½ and 4-year-old child who is faced with intolerable anxiety and reacts in a truly "mad" or psychotic way.

Chapter XVI, A Developmental Study of Obsessional Neurosis, points up the idea of pathological degrees of affect control through specific symptom formation and through obsessive character formation. In this sense this type of neurosis may be thought of as a rampart against regression beyond a fixation point rather than the product of regression. In close association is Chapter XIX, The Psychoanalysis of Affect, in which there is an interesting discussion of primary tension-states derived from instinct, the components of which become fused into adult affects.

Chapter XI, A Psychoanalytical approach to the Classification of Mental Disease, is a masterpiece of definition and systemization together with diagrams showing phases of libidinal and ego development and the relation of neuroses, psychoses and "transitional states" to definite stages of mental development. This is a most readable chapter with many enlightening illustrations.

To the psychiatrist and psychologist not entirely familiar with Freudian theory this volume would be troublesome reading; yet it contains many valuable ideas for any thoughtful student of the genetics and dynamics of mental function. Controversy would surely arise as to whether such

sweeping deductions concerning the early development of the mind could be made from the psychoanalysis of adults without corresponding checks with the child analyst and the direct observer of child reactions over the first five years of life made by analytically trained observers. The author, however, has pointed the way for research from two directions through this genetic approach to the etiology of mental disease. By correlating the psychological mechanisms of mental illness with their origin and overdevelopment in childhood, he opens the way for studying more adequately the mental content of illness and thus obtaining a clearer diagnosis and prognosis, and also for observing infantile reactions during classical phases of mental organization.—MARGARET A. RIBBLE, M.D., New York City.

CHRISTIAN ESSAYS IN PSYCHIATRY

Philip Mairet, ed.

New York, Philosophical Library, 1956. 187 pp.

This is a symposium by ten British authors, five of whom are physicians (mostly psychiatrists), two theologians (one Methodist, one Roman Catholic), one an educational psychologist, and one (the editor) a journalist. The fact that five of them quote Jung extensively indicates his greater influence in Britain than in the U. S. Yet the editor remarks that Jung makes "many heretical statements" when developing his theological speculations. He recommends psychoanalytic writings only for their value to the instructed theologian. It is stressed by several of the authors that religion is an inescapable aspect of human existence and not to be ascribed solely to wish fulfillment. Freud's linking of religious with sexual development is criticized. The perniciousness of the attitude that the thought of sin is as bad as the act is pointed out. The Methodist contributor speaks thus of the creative value in the contact between psychiatry and religion: "A kind of psychology can emerge which is aware of the spiritual profundity of the human being, and a kind of religion whose dogmatic and conservative rigidity has been so vitalized that it can pass as a creative significance and spirit into the life of the modern individual . . . the tensions between psychology and religion should be viewed as labor pains by means of which something more intelligently Christian can be born" (p. 110).

Although the quality of these essays is uneven, from the best of them the American reader can learn the outstanding views of several of the leaders in British psychotherapy and pastoral psychology. They are recommended to the attention of that growing body of psychiatrists, psychologists and clergymen who wish to bring about creative interplay among the members of their respective professions.—ROBERT A. CLARK, M.D., Friends Hospital, Philadelphia.

YOUTH IN A SOUNDLESS WORLD: A SEARCH FOR PERSONALITY

By Edna S. Levine

New York, New York University Press, 1957. 217 pp.

Miss Edna Levine, a clinical psychologist obviously competent and dedicated to her task, studied deaf children and adolescents not only by various test techniques but with a perceptive empathy that penetrated to the human essence of the problem. In a limpid and frequently vivid style, Miss Levine ably describes the indispensable roles sound and then words play in the imagery, value systems and successive social roles of the hearing child, the tragic hiati left in these fields in the deaf-mute,

and the skillful and sometimes heroic efforts necessary if these central deficiencies are to be corrected or compensated. Thus (p. 192): "The hearing child's path is relatively clear-cut and direct; the deaf child's generally roundabout, tortuous and different. But the goals are the same. Both seek inner fulfillment and emotional harmony." Miss Levine's recommendations for therapy: not "education" alone but also individualized psychological and mental health services by sympathetic therapists specially trained in the problems of establishing *rapport* and communication with the deaf.

A final section hails the support by the U. S. Department of Health, Education and Welfare of the establishment of a special center for research in and treatment of deafness—a field to which this little book is a stimulating and valuable contribution. —JULES H. MASSERMAN, M.D., Chicago.

HUNTERDON MEDICAL CENTER

By Ray E. Trussell, M.D.

Cambridge, Harvard University Press, 1956. 236 pp.

Hunterdon Medical Center carries the modest sub-title, "The Story Of One Approach to Rural Medical Care." It is much more than that. It is the story of people working together effectively to meet their health needs. It is the story of a new experiment in medical care organization. It is the story of a community's willingness to forget meaningless traditions and establish fresh and exciting concepts. This book makes fascinating reading for anyone concerned with how to make medical care of high quality more widely available. Many will want to borrow from the ideas it chronicles; all will find a challenge in its message.

Hunterdon County is a semi-rural area with a population of 40,000 bordering the Delaware River on the western edge of New Jersey. Dr. Trussell writes of what happened in that county from the time, in early 1946, that "the need for a county hospital was discussed" by the County Board of Agriculture. He tells of the evolution of the community's determination to build not "just another hospital" but a "progressive institution with a university affiliation, a model of its kind, aimed to bring what is best in medicine to the residents of a rural area . . . ." The fund-raising drive brought $993,000 from 7,316 contributors. "Hunterdon County became so Medical Center conscious that when the Anti-Horse-Thief Society disbanded after years of inactivity its treasury of $700 went to the Medical Center." We learn in detail of the planning that preceded the groundbreaking in 1951, and of the first two years of the Center's operation.

Dr. Trussell, now the executive director of the School of Public Health and Administrative Medicine at Columbia University, is in a unique position to tell the Hunterdon story. He became the center's first director, in 1950, and remained in that position for five years. "No formula of words can express what he gave us in thought, dedication and tireless effort," writes the president of the board of trustees.

The Hunterdon Center has a group of full-time, salaried physicians, appointed by the board of trustees in consultation with New York University Medical Center. Each of these physicians has a faculty appointment at NYU and spends one day a week at the NYU Medical Center. This staff of specialists counsels and advises general practitioners in the community. The hospital, with its staff, "represents the medium by which patients remain under the care of the family physician, who in turn has the complete cooperation . . . of a full-time

specialist staff." The ways in which the general practitioners of Hunterdon County now work with the salaried staff of specialists attached to the Medical Center provides new insight for those who are concerned about the place of the general practitioner in modern medicine.

The significance of the Hunterdon experience is in providing an organization to give rural community medical care which meets university medical center standards. The successful relationship worked out between the Hunterdon Medical Center and New York University—Bellevue Medical Center provides an important demonstration of how concepts of regionalization can be effectively implemented.

Mental health concepts were taken into account in every step—from architectural planning and decoration to arrangements for conferences with teachers, principals and school nurses. The close working relationship between specialists and general practitioners has important implications in the mental health field.

Strong lay local leadership was a key factor in the development of the Hunterdon program. The Center's president, Lloyd Wescott, and his local associates had the foresight to go beyond local sources for planning help—first to Dr. E. H. L. Corwin, who made the first survey, and then to such leaders as Dr. Lester J. Evans and Dr. Clarence E. de la Chapelle, and finally to Dr. Trussell.

The description of how this community raised the funds to finance its Medical Center is inspiring. But there is a real question as to whether similar communities could duplicate this effort. The common assumption that the responsibility for financing medical care facilities should be undertaken by the local community, through voluntary efforts, with governmental help limited to a relatively small amount of Hill-Burton money, is open to serious question. For Hunterdon, the Commonwealth Fund provided a construction grant of $250,000 at a time of crisis, and other gifts for special projects. Such outside help would probably not be available elsewhere. Added funds from government for programs like this in other communities and for other new experiments in the more effective organization of medical care could provide the impetus for the development of modern patterns of medical care.

Dr. Trussell indicates that "the day is past for depending on a few wealthy people to support hospital services for the entire community. Hunterdon County is theoretically and actually in a position to experiment with a broad prepayment program." Coupling prepayment with this kind of an effectively organized and integrated hospital-medical care system has the potential for bringing to most Americans a vastly improved quality of health care.—JAMES BRINDLE, International Union of United Automobile, Aircraft and Agricultural Implement Workers.

HUMAN PROBLEMS OF A STATE MENTAL HOSPITAL

By Ivan H. Belknap, Ph.D.

New York, McGraw-Hill Book Co., 1956. 277 pp.

To this reviewer, at least, *Human Problems of a State Mental Hospital* is even more depressing in its implications than are those stories, accompanied by photographs, appearing in newspapers and magazines that purport to "tell the truth" about state hospitals for the mentally ill. Appalling as are the stories and pictures, the problems presented are those that would supposedly lend themselves to vast and immediate amelioration were far more money, much

larger professional staffs and the interest of the public only available. Dr. Ivan Belknap's study of the social structure of "Southern State Hospital" indicates clearly, however, that unless profound change can be made in the internal organization and system of social relationships of this and other state hospitals, additional funds, professional personnel and public concern will not, in themselves, produce a therapeutic environment or even comfortable and pleasant custodial care.

The analysis of social structure offered the reader rests upon theories developed largely during the last quarter of a century by social scientists interested in formulating concepts and research methods for studying social organization. The results of the analysis are of an order that makes the reader ask himself as he closes the book, "If hospital personnel had intentionally set out to create a system that would rob both ward staffs and patients of initiative, respect, recognition and sympathy, could they have succeeded much more effectively?"

Why should anyone expect ward staffs to provide conscientious, considerate care of psychotic patients when they themselves are not only treated as second-class citizens but are rarely provided with psychological support and encouragement in the anxiety-inducing situations under which they work? Why should anyone expect patients to do other than regress emotionally on those dreary wards where the predominant form of "treatment" is control exercised by neglected attendants and by other patients higher in the patient hierarchy? Does anyone assume that social workers, nurses, clinical psychologists generally will exert themselves to the utmost in behalf of unloved patients and relatives when no systematic effort is made even to find out the scope of the work for which they have been prepared or to give them an opportunity to function, with professional recognition, on the higher levels of their competence?

These are only a few of the untoward consequences that tend to result from a system where all staff—and patients—are graded according to sharply defined levels of authority and prestige. Why should psychiatrists who have received no training in institutional management, in working with other categories of staff except hierarchically or with psychotic patients in ward and group situations—why should they run "hospitals" in which only a small fraction of the patients receive psychiatric treatment? Couldn't the large mental institution employ psychiatrists expressly to give psychiatric treatment insofar as possible to all patients who would benefit from such treatment? Could it not also employ general medical doctors, dentists, oculists to care for the physical needs of *all* patients? Could it then move to create other services coordinate in importance with the psychiatric-medical service, staffed with persons who have had formal preparation and/or experience in management; in instituting "social treatment" the efficacy of which has been demonstrated on wards where no psychiatric therapy is offered; [1] in planning for relations with families, community agencies and the public; in experimental attempts to motivate staff and patients, and in helping both groups develop greater interpersonal competence? Such are the pertinent questions to which Dr. Belknap's analysis leads.

Lest there be any misunderstanding, it should be emphatically said that many individual psychiatrists have acquired great skill in administration, in creating thera-

[1] Milton Greenblatt, Richard H. York and Esther Lucile Brown, *From Custodial to Therapeutic Patient Care in Mental Hospitals*, New York. Russell Sage Foundation, 1955.

peutic situations within the hospital, or in working effectively with "auxiliary personnel." But that skill is not the direct product of their training in psychiatry, which probably places less emphasis upon preparation for administration and supervision, including the social psychological aspects of management, than do several other forms of graduate work now available. With notable exceptions, moreover, psychiatrists possessing such skills do not want to ally themselves with the large mental hospital as it currently exists.

One serious omission occurs in Dr. Belknap's analysis—an omission that probably makes the picture of "Southern State Hospital" appear a little more distressing than it actually is. Not enough is said about the amelioration of circumstances that may occur through the informal system of social relations which exists concurrently with the formal system. As Otto Von Mering and Stanley H. King seek to demonstrate in *Remotivating the Mental Patient*,[2] encouraging changes are frequently found in some parts of institutions where the general social system has been little improved. If only to protect themselves from an otherwise intolerable job, occasional attendants succeed in conspicuously modifying the environment of their place of work. Other attendants have deep feelings of sympathy for sick persons and a true sense of mission in helping them. Others have gained enough knowledge and confidence from their initial in-service training to begin and maintain their work on a higher level of skill and motivation. In some hospitals "top administration" may even be unaware of the existence of the more favorable situations that have been created; in other hospitals changes have been effected with the general support and blessing of supervisory and administrative personnel although there has been no comprehensive reorganization of the system of social relationships.

In a reference (p. 251) Dr. Belknap pays tribute to the existence of such ameliorative influences at "Southern State." Recognition that mental patients are sick persons who need help and sympathy is an important source of motivation, says he, particularly among the women attendants. Many are "devout members of rural Protestant churches and tend regularly to frame their conceptions in terms of Christian religious duty. These attendants are largely responsible for most of the daily acts of kindliness and thoughtfulness we found. . . . They arranged birthday parties and bought presents for patients without families, and they often gave money to patients for small canteen purchases."

Unfortunately the author did not pursue this subject farther. Hence we have no picture of the extent or the continuing vitality of the desire to give patients a better deal, a desire inspired largely perhaps by religious and family conditioning rather than by efforts of the hospital to help staff make an emotional investment in their job. To disregard such relationships between ward staff and patients, no matter how unimportant they may appear within the total pattern of authority and power, may distort the report of the patient care provided and may fail to give recognition to a potentiality for change.

Regardless of the antiquated social system of most state hospitals, at least some alterations are made that produce more effectiveness in working within its limitations. In places where almost no psychiatrists could be recruited, clinical psychologists or social workers have sometimes been employed who have held group discussions with patients and often also with

[2] New York, Russell Sage Foundation, 1957.

ward staffs. Such discussions have furnished opportunity for the release of tension and anxiety, for psychological support and encouragement, for constructive suggestions. Volunteers have brought to hospitals not only supplies and recreational, educational and religious programs, but their very conviction that patients *could* improve has sometimes modified an atmosphere of hopelessness. The use even of small areas of state hospitals for furnishing nursing students with experience in psychiatric nursing has achieved conspicuous direct and indirect results in patient care. Utilization of nurses in supervisory and teaching positions who could give supporting rather than authoritarian help to ward staffs and who could carry on continuing in-service programs has raised morale, improved staff performance and produced desirable changes in ward environments.

Growing sophistication about the importance of interpersonal relations as a therapeutic instrumentality is perhaps becoming more apparent than at any time since the days of moral treatment. Many of the neuropsychiatric hospitals within the Veterans Administration have made marked gains in reducing some of the liabilities of their formerly rigid hierarchical structures. Such changes are applicable to other large mental institutions. We should like to end this review with one of many illustrations that might be given.

Just as *Human Problems of a State Mental Hospital* was reaching its first readers, a Veterans Administration hospital located in the same area as the institution described by Dr. Belknap issued invitations to some sixty representatives of nursing from other federal psychiatric hospitals in the region. The invitation was prefaced by the following statement: "The theme of this two-day institute is Improved Patient Care through Psychological Support of Staff. Our chief objective is to study means by which we may better provide feelings of belongingness for all of our people. We recognize that what hospital employees who work most closely with patients want is much like what workers everywhere want. They want the feeling that what they are doing is important and that it is recognized as such by those higher in authority and by their own category of staff. They want that recognition to be demonstrated in positive terms not only of praise or of being asked for opinions concerning ward matters with which they are well acquainted, but they want to be given the feeling that they are part of a group therapeutic effort. We hope, through this institute, to work toward meeting these needs."

Attached was a list of questions that had been prepared as suggestions for the small-group discussions. "How can we provide employees with 'feelings of belonging'? What do staff expect in the way of psychological support? What do we mean by 'team concept' and what does it include? How does communication affect psychological support?" As concrete recognition of the value of attendants (or nursing assistants as they are now called), provision was made whereby all of them could attend one of the two open meetings and could report both formally and informally on their role and its significance in patient care. As the writer observed these nursing assistants speaking to a large audience that included the "top administration" of the hospital, she concluded that a considerable distance had been traveled on the road toward a goal of all personnel's perceiving themselves and being perceived as partners in patient care. — ESTHER LUCILE BROWN, Ph.D., Russell Sage Foundation and Boston University School of Nursing.

Guest Editorial

For nearly a quarter of a century the National Congress of Parents and Teachers has sponsored the summer round-up program, which has emphasized the importance of physical and dental examinations for every child about to begin his school career.

Recent action of the National Congress has enlarged the scope of the program to include continuous health supervision of all children of preschool age through high school. Involved will be the education of parents, the establishment of close cooperation with community health organizations and agencies and the promotion of a closer relationship of parents and children with their family physicians and dentists.

Initiating and expediting this expanded program implies an interest in many new areas of concern. It may therefore be appropriate and timely to call attention to the mental health aspects of "continuous supervision" and to suggest several basic considerations which, if kept in mind, might be of help in this expansion.

Problems associated with the mental health of both young and old are of national concern. It is an area which has a high priority on the health needs of the present day and should be included in the program of continuous supervision.

What may the goals be for our children which would help them achieve a measure of mental health? For every child in our society the ultimate goals should be to help him:

- To develop to the maximum his basic potential.

- To learn to live happily and productively with others.

- To learn to appreciate and accept his strengths as well as his weaknesses or shortcomings.

Important also is the development of healthy attitudes toward self, others and the tasks of daily living. Achieving these goals should assure every child an opportunity to enjoy a reasonable state of mental health.

It must be recognized that the goals of living change with each successive stage of maturation from infancy through adolescence. For the infant the primary goal is the full gratification of all basic needs—physical, emotional, social and intellectual. During childhood the goals shift toward the development of a concept of self in relation to others and toward the development of skills and techniques for increasing independent action and responsibility. For the adolescent it is important eventually to sever the dependency ties upon the home and to continue the development of his capacity to assume the responsibilities of the adult in terms of interpersonal relationships, work and community responsibilities.

Every individual is the product of several interacting forces or influences. These are:

- His innate endowment.

- The basic attitudes which parents and parental surrogates have toward him and their understanding of basic principles of growth and of their respective responsibilities toward him which are influenced in large measure by a third force, which is

- The culturally determined child-rearing practices of the community.

Most of our children grow up in families with fathers, mothers, brothers and sisters.

It is the home where the child learns many of life's fundamental lessons. It is here he learns about himself and others. Here he develops his skills in managing his interpersonal relationships and learns to meet competition, to accept criticism, blame and praise. It is here he learns the basic lessons of obedience to authority—so essential to happy living. In the security of a home tempered with parental patience, tolerance and understanding help assures the development of the much needed sense of "belonging." These and many other lessons are learned in the home and later strengthened in the school with the help of parents and parental surrogates, teachers, counselors and principals.

To assure the child maximum help as he matures it is essential that parents and substitute parents (such as teachers, physicians, dentists, etc.) understand and accept their role and responsibility in the process. Many could be listed. However, of prime importance are the following:

- To provide the opportunity for the child to develop his potential in accordance with his individual pattern and tempo.

- To teach patterns of self-control all along the way by example and by helping the child to accept the limits defined for him.

- To represent and interpret the world of reality to the child so that he will develop an understanding of it and in the process will develop ways and means of meeting the requirements of successful living.

Personality growth is a continuous process of differentiation and integration. It is an orderly process in which sequence follows sequence in a fairly predictable time relationship. However, it must be recognized that each child develops in accordance with his own individual tempo and pattern which must be respected and protected.

Since growth is a process, it cannot be forced nor delayed without causing trouble for the child and others.

Maturation from infancy on through the developing years is a slow but steady change from a state of dependency and complete helplessness to one of independency, self-sufficiency and finally a recognition of interdependency.

An intrinsic part of growth is tension or stress. It is essential to the process but must be kept in reasonable balance so as not to exceed the individual capacity to function adeqately. It should be regarded as detrimental only when its proportions exceed the tolerance capacity of the child. Should this occur, the causative factors require exploration and definition.

Every normal child is born with the ability to perform a few but important independent tasks for himself. However, survival depends upon others who, with understanding and sustaining support, can and should guide the child by offering their acceptance and love and providing full gratification of needs (particularly in infancy and early childhood). Needed also is help to learn a well circumscribed set of limits and to master frustration which often comes through denial. Accorded the opportunity to make decisions commensurate with age and ability helps to develop an attitude of self-sufficiency. Confidence and a sense of adequacy comes through doing and sharing achievements with others.

Children reared in accordance with these basic concepts will have better opportunities to learn together with us all how to live and work together happily and pro-

ductively, and thus may be assured an enriched measure of mental health.

Since the assistance of physician and dentist will be important to the program of continuous health supervision, it may be appropriate to call attention to several changes which will occur.

Traditionally medical (including dental) personnel have been trained to know, understand and treat illness and disease of mankind. To function adequately in the program of continuous health supervision it will be essential to develop our understanding of the child—his needs, the nature of developmental processes and the principles of child management. This will be important in the education of parents and in the clarification of their doubts, worries and faulty attitudes. More adequate means of communications with parents, children and the school will require consideration. Of necessity this will be a slow and at times discouraging process. However, with the child's ultimate welfare in mind, and a willingness to explore the possibilities intrinsic to this proposed program, ways and means will be found to enhance the life of every child. Its success would be a real contribution to the development of an effective program of preventive mental health services. Important also will be the early recognition of behavioral disturbances and the development of skills and techniques to help parents resolve them.

—Reynold A. Jensen, M.D., University of Minnesota Medical School.

Notes and Comments

MENTAL HEALTH ASSEMBLY

Encouraging gains in research, rehabilitation and community-hospital cooperation were reported by many of the 425 lay and professional workers who met November 20–24 in Atlantic City for the National Mental Health Assembly and annual convention of the National Association for Mental Health.

The 750 state and local mental health associations and the 7-year-old NAMH also made gratifying organizational progress last year, noted F. Barry Ryan, Jr., retiring president. He reported growth in the number of affiliated state and local mental health associations, expanded services to patients and their families and to the general community, and considerable gains in fund-raising.

The general hospital is rapidly becoming a place where patients with even the most severe mental illnesses can receive treatment, Dr. Milton Rosenbaum of New York City said at one of two general sessions on the community and the hospital. He is chairman of the department of psychiatry of the Albert Einstein College of Medicine.

He also made a plea for the "no locked door" policy in the treatment of psychiatric patients, charging that many symptoms result from this type of restriction, rather than from the basic mental illness.

Stressing the therapeutic importance of keeping the patient in the community, Dr. Rosenbaum said, "It is better to maintain contact between the patient and his family since separation, isolation and feelings of being rejected and abandoned may be increased by sending the patient to a distant hospital or sanitorium."

Other advantages of psychiatric units in community-based general hospitals are these, Dr. Rosenbaum added:

- Standards of care of mental patients are improved and they are no longer considered as 2nd-class citizens.
- Misunderstandings about mental illness among hospital staff and in the community are broken down.
- Internes and residents are attracted to psychiatry as a specialty.
- Patients with acute psychiatric complications of medical and surgical illnesses can be treated psychiatrically in the hospital.
- Psychiatrists serving in a general hospital are apt to become involved in preventive psychiatry in the surrounding community. In this way, the hospital not only offers an opportunity for the diagnosis and treatment of the mentally ill, but becomes the center for the promotion of mental health.

Dr. Warren T. Vaughan of Cambridge, Mass., called on mental health associations to encourage the public to think of the hospital as a health center treating mental as well as physical ills, and to think of the psychiatrist as a logical member of the community hospital team. A serious and determined effort should be made, he said, to develop prepayment plans covering psychiatric illnesses. He termed this "really an emergency."

Dr. Vaughan is with the Joint Commission on Mental Illness and Health as associate director of a task force on patterns of patient care.

In a paper on education of the public, Dr. John H. Cumming, research director for the Greater Kansas City Mental Health Foundation, pointed out a great change had come about during the last six years in public readiness for involvement in com-

munity action to combat mental illness, and recommended that mental health associations undertake an action program of public education. The objective of this program should be, he said, "to make the standards of care for the mentally ill in all our state hospitals equal to that which is given in the best state hospitals."

As examples of action programs likely to lead to improved community attitudes and beliefs about the mentally ill, he cited hospital visiting programs, organization of rehabilitation centers for discharged patients, and formulation of job-finding committees.

The volunteer is the life blood of the mental health movement, Mrs. W. Jasper DuBose reminded the delegates. She is director of volunteers in the eastern area office of the American National Red Cross.

Discussing volunteer service to psychiatric patients in hospital and community, Mrs. DuBose said the best volunteers do not try to fulfill all of the patients' needs by indiscriminate giving and doing. Instead, they try to set goals that patients in various stages of recovery can handle. She noted that "it takes perceptive analysis and skillful exploration" to determine what these goals should be.

"Volunteers can be interpreters, advocates and at times stern critics," said Mrs. DuBose. "They can be of inestimable value in telling the community what the hospital does, why it does it and why it does it the way it does.

"And they are strong reminders that the hospital belongs not to itself but to the whole community," she added.

Workshop discussions focused largely on the changing role of the state mental hospital and on the growing importance of the services provided to both hospital and community by state and local mental health associations.

The delegates noted with approval the growing tendency to consider the well-being of the mental patient as a responsibility shared by state and community. They insisted, however, that the mental hospital should be a dynamic force in the community and not a catch-all for patients rejected by general hospitals.

They cited 7 ways mental health associations help to further close ties between hospital and community:

- By periodically visiting the hospital, learning first-hand what its psychiatric needs are and planning programs to meet these needs.
- By interpreting the hospital's problems to the community.
- By communicating the community's needs and desires to the hospital.
- By studying, sponsoring and following up sound legislative measures.
- By working with responsible government departments in developing a master plan for integrated community mental health services and by cooperating with other agencies in carrying out the plan.
- By cooperating closely with psychiatrists and involving them in the work of the mental health association.
- By providing a corps of trained, dependable mental health volunteers.

Describing experiments now underway in federal government laboratories, Dr. Seymour S. Kety, research director for the National Institute of Mental Health, stressed the difficulties in investigating the causes of schizophrenia. As an example, he cited that tests on patients from hospital "back wards" are more likely to reflect the effects of long-term hospitalization than to provide clues about a specific disease.

Dr. Kety also noted the current theory that organic phenomena are the bases for mental illness, and declared this or any other dogma out of place in the study of mental illness.

A general view of mental health research in the U. S. today was provided by Albert Deutsch, author of the ground-breaking 1937 study, *The Mentally Ill in America*. With a grant from NAMH, Mr. Deutsch recently visited representative research centers throughout the country and is now writing a book reporting his observations.

Noting that "recent years have witnessed significant and encouraging developments in the treatment of mental illness," he asserted both scientists and laymen should maintain a cautious attitude toward sensational claims of new cures. It is the layman's task to support a wide variety of biochemical, socio-environmental and psychological studies, he said, leaving it to the scientists to decide priorities and to maintain the highest scientific standards.

In sessions on rehabilitation of the mental patient, speakers agreed the hospital's responsibility to the patient does not end until he is again ready to return to normal social life. With help from the community, the hospital should provide a wide variety of services that help the patient bridge the gap between the hospital and satisfactory adjustment in the community.

Dr. Peter A. Peffer outlined three novel rehabilitation techniques in use at the Veterans Administration Hospital in Brockton, Mass., where he is manager. He said they have added greatly to the hospital's ability to release some of its most difficult patients.

• The member-employee program provides that chronic mental patients whose condition is somewhat improved may be discharged as patients and hired as hospital employees at modest salaries plus food, quarters, laundry, medical and dental care, and recreation. They are free to leave the hospital after work. They are also helped to find jobs in the community and thus to leave the hospital altogether.

• Another program, designed for patients showing little or no improvement, combines occupational therapy with a money incentive. Severely regressed patients, put to work in a ceramics workshop in the hospital, are paid from 50¢ to $2.50 a week. Mental health volunteers raise funds to buy equipment and material for the patients, and sell their ceramics. Dr. Peffer said this program was so successful "that a number of these patients progressed to member-employee status, or were placed at higher level hospital assignments, eventually achieving trial visit status and subsequent discharge from the hospital."

• The foster home cottage plan aims at preparing patients for discharge to foster homes in the community. These are generally patients who have arrived at a good level of recovery but whose employment potential is low because of age or physical disability, Dr. Peffer said. They live in a homelike 10-room house on the hospital grounds, sharing its dining room, kitchen, living room and hobby shop and its garden, where they grow flowers and vegetables. In the cottage they take care of serving their own meals, cook part of their food, wash the dishes, clean their own rooms, keep the area around the cottage neat, cut the grass. They also learn about 90 household jobs such as fixing light plugs and replacing faucet washers.

Pointing out that last year 60,000 former mental patients, unable to make a successful adjustment in the community, had to return to the hospital, John H. Beard, executive director of New York City's famous

Fountain House, said "the high rate of rehospitalizations demands immediate attention in communities throughout the country."

In a paper on the social aspects of rehabilitation, Mr. Beard called for research designed to screen those most likely to be readmitted and therefore most in need of rehabilitation, so that community agencies could give these patients a high priority on their services. Illustrating his point, he said approximately 40% of 356 men and women who asked for help from Fountain House and were temporarily turned down for lack of staff and facilities had to go back to the mental hospital.

Besides finding suitable quarters and jobs, Mr. Beard noted, the discharged mental patient has to learn how to get along with people, a problem frequently made extremely difficult for him by the very nature of his illness. An environment like that of Fountain House permits the convalescent to "practice" being again with people, he said.

Pioneer efforts of the San Francisco Association for Mental Health to draw employers into the process of breaking down widespread prejudice against hiring former mental patients were described in a paper prepared by Mrs. Joan Fell Murray, the association's retiring executive director, and read by her successor, J. Gilmore Marquis. Urging other mental health associations to form similar employers' committees, Mrs. Murray pointed out that "this group will be willing not only to help find the solution to the employment problem, but to the whole range of problems which community leadership must deal with relative to mental illness."

In a paper on vocational rehabilitation of the mental patient, Bertram J. Black of New York City discussed the work of Altro Health and Rehabilitation Service, of which he is executive director.

He stressed the cost of integrated rehabilitation services for the mentally ill, and pointed to the array of services that must be provided: vocational counseling, case work, medical attention and "the socializing and training influence of the sheltered workshop."

Experience, he said, had shown that "money is a powerful incentive to rehabilitation of the psychotic." He noted that 87 out of 100 Altro "graduates" succeed in maintaining themselves in the community and on the job or in homemaking without other services than continued psychotherapy or occasional medical supervision.

In workshops, conference delegates agreed that rehabilitation starts when the patient realizes he is sick and terminates only when he recovers and is fully reintegrated in the community.

They saw a steadily mounting demand for mental health associations to take the lead in assuring the provision of adequate rehabilitation services, and said they should assume the responsibility of providing information about local services, organizing public action (including new legislation, if necessary) for better services, and keeping constantly before employers and the general public the assurance that with their help the mentally ill can come back—and stay back—in the community.

HOSPITAL ROLLS DECLINE

Mental hospital rolls, which in 1956 showed a decline for the first time in 25 years, are still continuing their downward trend, the National Association for Mental Health reported in November.

Addressing the annual meeting of NAMH members, F. Barry Ryan, Jr., retiring president, said that in 20 representative states the number of resident patients in state and county mental hospitals

dropped by 2,500 between June 1956 and June 1957. Projecting these figures to the entire United States, Mr. Ryan estimated a total reduction of about 5,000 in the nation's mental hospital population during this 12-month period.

"It is important for us to note," said Mr. Ryan, "that this decrease has occurred in the face of a continually increasing admission rate. Because of increased discharges and because of expanding mental hospital facilities throughout the country, it was possible for the hospitals to admit and to treat many more patients than in previous years. Yet, in spite of this, the overall figures on resident patients fell by about 7%."

Mr. Ryan warned, however, that the optimistic mental hospital picture "may be blinding us to the true state of affairs still existing in many of our hospitals today.

"Many of the advances we have seen have been the result of an expanded program of concentrated, intense treatment for new patients. The majority of the other patients—those who have been there a year or longer—are getting little or no treatment at all."

LEGISLATION

Congress voted $39,217,000 for the National Institute of Mental Health—$4,000,000 more than last year. Half the increase goes for additional research training and fellowships. Juvenile delinquency, aging, mental retardation, alcoholism and accidents are the major mental health problems, Dr. Robert H. Felix, NIMH director, said during the budget debate.

California's new community mental health services act became law on September 12. The state will now pay half the cost of mental health services provided by local governmental units, either city or county.

The California legislature also boosted the budget for the State Department of Mental Hygiene to $115,772,340, largest in history. The department is now looking for employees to fill more than 2,000 new positions. To bring the level of care for mental patients to 90% of the department's standard, it needs 1,120 more ward attendants, 109 more psychiatrists and other physicians, 39 more clinical psychologists, 108 more psychiatric social workers and hundreds more therapists of various kinds, teachers, technical, maintenance and clerical workers.

PUBLICATIONS

Significant papers by 12 authorities on specific aspects of the mental health field have been published as a book titled *Programs for Community Mental Health* by the Milbank Memorial Fund.

It covers such topics as the place of the voluntary health agencies in community mental health programs, planning for mental health in metropolitan and in rural areas, the changing roles of state mental hospitals and psychiatric outpatient clinics, and the future role of the psychiatric division of the general hospital.

It is a sequel to *The Elements of a Community Mental Health Program,* published in 1956, and is available for $2 from the Milbank Memorial Fund, 40 Wall St., New York 5.

Current Practices in Mental Hospital Administration is the title of a new American Psychiatric Association publication. It is a collection of 18 articles by as many outstanding mental hospital directors covering most of the major aspects of hospital administration. The articles originally appeared in the magazine *Mental Hospitals.* The collection is available from the APA Mental Hospital Service for $2 a copy.